

<b>Case Number:</b>	CM15-0092231		
<b>Date Assigned:</b>	05/18/2015	<b>Date of Injury:</b>	03/07/2014
<b>Decision Date:</b>	06/18/2015	<b>UR Denial Date:</b>	04/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/13/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 33 year old female who sustained an industrial injury on March 7, 2014. She reported an injury to her right upper extremity. Previous treatment includes home exercise program, medications, chiropractic therapy, and work modifications. Currently the injured worker complains of right elbow pain and discomfort. NCS/EMG on 4/22/2014 revealed mild carpal tunnel syndrome and mild right ulnar at the elbow showing conduction velocity. An MRI of the cervical spine on 5/21/2014 revealed degenerative disc signal without thinning at C5-6 and C6-7, mild reversal of the cervical lordosis at C5-6, and central and right lateral disc protrusion. Diagnoses associated with the request include right ulnar neuropathy, cervical spine sprain, lesion of the ulnar nerve and right forearm muscle strain. The treatment plan includes continuation of Salon pas, medications; repeat NCV/EMG, right elbow peripheral artery disease, continued home exercise program and chiropractic therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Additional chiropractic 1-2 times a week for 3-6 weeks x6 sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines manual therapy & manipulation Page(s): 58-60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow, Manipulation.

**Decision rationale:** MTUS states, "Recommended for chronic pain if caused by musculoskeletal conditions." MTUS additionally quantifies, "b. Frequency: 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached plateau and maintenance treatments have been determined. Extended durations of care beyond what is considered 'maximum' may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities." ODG states "Recommended only on a short-term limited basis as indicated below. Insufficient evidence exists to evaluate many physical modalities, including manipulation, used to treat disorders of the elbow, often employed based on anecdotal or case reports alone. In general, if approved on a limited basis, it would not be advisable to use these modalities beyond 2-3 visits if signs of objective progress towards pain reduction VAS greater than 4 change and returning to regular work is demonstrated. (Bisset, 2006) (Boisubert, 2004) According to one retrospective review, most lateral epicondylitis patients had successful outcomes regardless of the inclusion of manual therapy interventions to the cervical spine. The Local Management + Manipulation group achieved the successful long-term outcome in significantly fewer visits. (Cleland, 2004) (California, 1997) (Pilgian, 2000) (Boyer, 1999) (Sevier, 1999) (Geldschlager, 2004) A recent small study concluded that manipulation of the wrist appeared to be more effective than ultrasound, friction massage, and muscle stretching and strengthening exercises for the management of lateral epicondylitis when there was a short-term follow-up. However, replication of these results is needed in a large-scale randomized clinical trial with a control group and a longer-term follow-up. (Struijs, 2003) This review determined, with good evidence, that a number of treatments, including acupuncture, exercise therapy, manipulations and mobilizations, ultrasound, phonophoresis, and ionization with diclofenac all show positive short term effects in the reduction of pain or improvement in function for patients with lateral epicondylitis. (Trudel, 2004) See also Manipulation under anesthesia (MUA), a different procedure. ODG Chiropractic Guidelines Elbow: Up to 3 visits contingent on objective improvement documented (ie. VAS improvement greater than 4). Further trial visits up to 3 more contingent on further objectification of long-term resolution of symptoms, plus active self-directed home therapy." The medical documentation provided indicate this patient has had an unknown number of chiropractic sessions. The treating physician has not provided documentation of objective functional improvement from this therapy. As such, the request for Additional chiropractic 1-2 times a week for 3-6 weeks x 6 sessions is not medically necessary.

**NCS electromyography right upper extremity ulnar neuropathy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS) and Other Medical Treatment Guidelines CMS.gov, Decision Memo for Electrodiagnostic Sensory Nerve Conduction Threshold (CAG-00106R).

**Decision rationale:** ACOEM States "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful." ODG further clarifies "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." CMS also specifically writes regarding sensory or voltage type nerve conduction testing, "Based on the evidence as a whole, CMS concludes that the use of any type of s-NCT device (e.g., 'current output' type device used to perform CPT, PPT, or PTT testing or 'voltage input' type device used for v-NCT testing) to diagnose sensory neuropathies or radiculopathies." The treating physician has not met the above ACOEM and ODG criteria for a nerve conduction testing of the upper extremities. This patient had an EMG in 2014, the treating physician has not provided documentation of objective findings or subjective complaints that warrant repeat testing. As such the request for NCS electromyography right upper extremity ulnar neuropathy is not medically necessary.

**MRI right elbow:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Elbow.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 33-34. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow (Acute & Chronic), MRIs.

**Decision rationale:** ACOEM states, Criteria for ordering imaging studies are:-The imaging study results will substantially change the treatment plan. Emergence of a red flag. Failure to progress in a rehabilitation program, evidence of significant tissue insult or neurological dysfunction that has been shown to be correctible by invasive treatment, and agreement by the patient to undergo invasive treatment if the presence of the correctible lesion is confirmed. For most patients presenting with elbow problems, special studies are not needed unless a period of at least 4 weeks of conservative care and observation fails to improve their symptoms. Most patients improve quickly, provided red flag conditions are ruled out. There are a few exceptions to the rule to avoid special studies absent red flags in the first month. These exceptions include: Plain-film radiography to rule out osteomyelitis or joint effusion in cases of significant septic olecranon bursitis. Electromyography (EMG) study if cervical radiculopathy is suspected as a cause of lateral arm pain, and that condition has been present for at least 6 weeks. Nerve

conduction study and possibly EMG if severe nerve entrapment is suspected on the basis of physical examination, denervation atrophy is likely, and there is a failure to respond to conservative treatment. For patients with limitations of activity after 4 weeks and unexplained physical findings such as effusion or localized pain (especially following exercise), imaging may be indicated to clarify the diagnosis and revise the treatment strategy if appropriate. Imaging findings should be correlated with physical findings. In general, an imaging study may be an appropriate consideration for a patient whose limitations due to consistent symptoms have persisted for 1 month or more, as in the following cases: When surgery is being considered for a specific anatomic defect. To further evaluate potentially serious pathology, such as a possible tumor, when the clinical examination suggests the diagnosis. ACOEM further recommends MRI for suspected ulnar collateral ligament tears and recommends against MRI for suspected epicondylgia. ODG writes regarding elbow MRI, "Recommended as indicated below. Magnetic resonance imaging may provide important diagnostic information for evaluating the adult elbow in many different conditions, including: collateral ligament injury, epicondylitis, injury to the biceps and triceps tendons, abnormality of the ulnar, radial, or median nerve, and for masses about the elbow joint. There is a lack of studies showing the sensitivity and specificity of MR in many of these entities; most of the studies demonstrate MR findings in patients either known or highly likely to have a specific condition. Epicondylitis (lateral "tennis elbow" or medial in pitchers, golfers, and tennis players) is a common clinical diagnosis, and MRI is usually not necessary. Magnetic resonance may be useful for confirmation of the diagnosis in refractory cases and to exclude associated tendon and ligament tear. Indications for imaging Magnetic resonance imaging (MRI): Chronic elbow pain, suspect intra-articular osteocartilaginous body; plain films non-diagnostic, Chronic elbow pain, suspect occult injury; e.g., osteochondral injury; plain films – non-diagnostic, Chronic elbow pain, suspect unstable osteochondral injury; plain films non-diagnostic, Chronic elbow pain, suspect nerve entrapment or mass; plain films non-diagnostic, Chronic elbow pain, suspect chronic epicondylitis; plain films non-diagnostic, Chronic elbow pain, suspect collateral ligament tear; plain films non-diagnostic, Chronic elbow pain, suspect biceps tendon tear and/or bursitis; plain films non-diagnostic, Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology." The medical notes provided did not document (physical exam, objective testing, or subjective complaints) any red flags, significant worsening in symptoms or other findings suggestive of the pathologies outlined in the above guidelines. The treatment notes do not indicate other extenuating circumstances to warrant deviation from the guidelines. As such, the request for MRI right elbow is not medically necessary.