

<b>Case Number:</b>	CM13-0045385		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	10/30/2009
<b>Decision Date:</b>	08/06/2014	<b>UR Denial Date:</b>	09/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2013

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Oklahoma, Texas, California and Tennessee. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 37 year old female who reported an injury to her right upper extremity. The clinical note dated 04/10/13 indicates the injured worker complained of right elbow pain specific with the anterior lateral region of the elbow. The note indicates the injured worker showing signs consistent with radial tunnel syndrome. The clinical note dated 05/09/13 indicates the injured worker having undergone an injection at the right elbow which did provide some benefit. The injured worker reported ongoing flare-ups. Upon exam, the injured worker was able to demonstrate full range of motion at the right elbow with tenderness over the medial and lateral epicondyles. The injured worker demonstrated positive Tinel's sign at the ulnar groove. The injured worker was also identified as having a positive Finkelstein's and Phalen's test. The note indicates the injured worker utilizing Motrin for pain relief. The clinical note dated 06/06/13 indicates the injured worker continuing with increased pain at the right upper extremity. The note indicates the injured worker being recommended for a surgical intervention. The clinical note dated 07/03/13 indicates the injured worker showing tenderness to palpation over the radial proximal form region. Minimal tenderness continued at the lateral region of the elbow as well as the epicondylar region. The clinical note dated 08/15/13 indicates the injured worker describing the pain as a dull, aching, sharp, shooting, stabbing, and pressure-like sensation. There was also an indication the injured worker was complaining of right shoulder pain as well. The agreed medical examination dated 09/03/13 indicates the injured worker complained of pain in the entire right arm. The note indicates the injured worker utilizing a soft splint at the right elbow and wrist with some benefit. A therapy note dated 09/23/13 indicates the injured worker having completed 3 physical therapy sessions to date.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RIGHT RADIAL TUNNEL RELEASE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 605.

**Decision rationale:** The request for a right radial tunnel release is not medically necessary. The documentation indicates the injured worker complaining of right elbow pain. A radial tunnel release is indicated for injured workers who have completed all conservative treatments for at least three months. There was an indication the injured worker completed three physical therapy sessions to date. However, no other information was submitted regarding the injured worker completing a full three month course of treatment. Given the lack of information concerning a completion of a three month course of treatment, this request is not indicated as medically necessary.

**POSTOPERATIVE OCCUPATIONAL THERAPY TWICE A WEEK FOR FOUR WEEKS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 17.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.