

Case Number:	CM13-0069393		
Date Assigned:	01/03/2014	Date of Injury:	12/27/2011
Decision Date:	04/11/2014	UR Denial Date:	11/22/2013
Priority:	Standard	Application Received:	12/20/2013

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 Orthopaedic Surgery, has a subspecialty in Hand Surgery and is licensed to practice in Texas. 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 patient is a 45-year-old female who reported an injury on 12/27/2011. The mechanism of injury was cumulative trauma related to the performance of job duties. The patient eventually sought treatment for pain that radiated into the arms and elbows with accompanying numbness to her fingers. The patient was diagnosed with severe carpal tunnel syndrome and was provided medications and braces, and her job duties were modified. Due to the lack of improvement in symptoms, the patient was referred for a cortisone injection that provided her with no benefit. The patient received an electrodiagnostic study on 01/24/2012 that revealed mild carpal tunnel syndrome of the bilateral upper extremities. There was reportedly no evidence of a peripheral neuropathy or cervical radiculopathy. An MRI of the right wrist performed on 01/24/2012 revealed possible de Quervain's tenosynovitis and scattered carpal bone cystic changes. An MRI of the left wrist performed on the same date revealed the same findings. The patient received a right carpal tunnel release on 08/10/2012 with significant relief. The patient later underwent a left carpal tunnel release on 12/10/2012 that was also significantly beneficial. Despite the significant decrease in symptoms to her bilateral wrists, the patient continued to experience bilateral elbow pain. She rated her pain as a 1/10 to 5/10 that significantly increased when she lifted anything. The patient received a steroid injection to the left lateral epicondyle on an unknown date that provided moderate relief. An MRI of the left elbow performed on 05/29/2013 revealed partial tearing of the common extensor tendon, as well as tendinosis, osseous degenerative change without acute abnormality; and supinator muscle edema/strain. The patient has no noted range of motion or strength deficits to the elbow, but tenderness was present to the lateral epicondyle. A repeat EMG/NCV performed on 06/24/2013 of the bilateral upper extremities revealed no evidence of recurrent carpal tunnel syndrome or specific entrapment or traumatic neuropathy. An ultrasound of the bilateral elbows was also performed on 08/29/2013

and revealed micro-tears, edema, and fibrosis to the left common flexor/extensor tendon origin, otherwise normal study. There was no other pertinent clinical information submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 left elbow lateral epicondylar release: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 2, 15, 34-36.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page(s) 44-45; and the Official Disability Guidelines (ODG), Elbow, Surgery for Epicondylitis.

Decision rationale: The California MTUS/ACOEM guidelines do not recommend surgery for lateral epicondylar release unless a minimum of 6 months of care that has included at least 3 to 4 different types of conservative treatment has been attempted and failed. The clinical information submitted for review has provided evidence that the patient has utilized medications and 1 cortisone injection that initially provided significant relief; however, the pain returned. There was no recent documentation of physical therapy specifically for her elbows. Other than the one cortisone injection medications, the patient has not utilized any other treatment modalities. The California Guidelines do not provide criteria for the use of an epicondylar release; therefore, the Official Disability Guidelines were supplemented. ODG states that for patients with severe entrapment neuropathies, 12 months of compliance with non-operative management, long-term failure with at least 1 type of injection, and failure to improve with NSAIDs, elbow bands and straps, activity modification, and physical therapy indicate the need for surgical intervention. Although the patient has subjective complaints, there was no evidence on electrodiagnostic testing that the patient suffered from a severe nerve entrapment. In addition, there is no evidence that the patient has received elbow-specific physical therapy or bracing. As there is no objective evidence of nerve entrapment and conservative therapies have not been exhausted, there is no indication for surgical intervention at this time. Therefore, the request for left elbow lateral epicondylar release is non-certified.

12 post op physical therapy sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

