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| Case Number: | CM14-0104288 | | |
| Date Assigned: | 07/30/2014 | Date of Injury: | 08/29/2011 |
| Decision Date: | 08/29/2014 | UR Denial Date: | 06/11/2014 |
| Priority: | Standard | Application Received: | 07/07/2014 |

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 California. 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:

This 47-year-old male sustained an industrial injury on 8/29/11. The mechanism of injury was not documented. The patient presented for initial hand orthopedic evaluation in October 2011 with ulnar sided wrist pain, evidence of extensor carpi ulnaris and triangular fibrocartilage tear, and some pain in the mid-section of the elbow of uncertain etiology. The patient failed conservative treatment and underwent release of the 6th dorsal compartment and repair of the triangular fibrocartilage. He did well post-operatively but the tenderness in the mid-section of the ulnar border of the forearm persisted. On 4/5/12, he underwent a limited release of the extensor carpi ulnaris fascial attachment to the ulna. This produced temporary improvement but eventually failed. On 7/30/12, a second attempt was made, essentially extending the area of the fasciotomy. The patient improved for approximately 4 weeks and the symptoms recurred as soon as more demanding therapy started. There was no specific diagnosis; a second opinion recommended a more extensive fasciotomy. The 2/6/13 orthopedic report cited that the extensor carpi ulnaris fascial attachment and pain over that muscle group diminished with the last surgery. Tenderness was reported over the flexor carpi ulnaris side of the forearm and extending for approximately 6 cm along the ulnar border of the ulna. A bone scan was obtained and was normal. The patient underwent an extensive fasciotomy to address both the extensor carpi ulnaris and flexor carpi ulnaris attachment to the periosteum of the ulna. Post-operative therapy increased the patient's pain and was discontinued. The patient was continued on a home rehabilitation program with good reduction in pain. The patient returned to full duty work on 7/8/13, but difficulty was noted with pallet jack use. Work restrictions were placed on 8/14/13. The patient presented on 11/6/13 with recurrence of his symptoms using the hand crank pallet jack at work. Pain was localized to the area slightly distal to the original area but along the course of the ulna. A request for surgery was submitted to redo at least the distal aspect of the

fasciotomy along the ulna. The patient was significantly better and had returned to work after the last surgery. The request for surgery was denied in utilization review as a repeat procedure was unlikely to offer any longer benefit. The treating physician rejected the basis for the utilization review. The patient reported significantly increased pain along the ulnar side of the forearm when he needs to crank the pallet jack at work. The 3/12/14 treating physician report indicated that patient was still symptomatic with deteriorating function. Maximum tenderness was noted in the mid-section of the scar, on the extensor rather than the flexor group. Surgery was recommended. The 6/11/14 utilization review denied the request for additional surgery as conservative treatment had not been instituted for the most recent flare-up, such as a cortisone injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Extensor Muscle Slide Procedure with or without an Epicondylectomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 43.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 35-36.

Decision rationale: The California MTUS guidelines state that surgical consideration for the upper extremity may be indicated for patients who have red flags of a serious nature, significant limitations of activity for more than 3 months, fail to respond to conservative management, fail to improve with exercise programs to increase range of motion and strength of the musculature; or clear clinical and electrophysiologic or imaging evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. Guidelines for epicondylalgia indicate that surgery generally should only be a consideration for those patients who fail to improve after a minimum of 6 months of care that includes at least 3-4 different types of conservative treatment. Guideline criteria have not been met. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. The patient has had good short term relief with the surgical procedures provided and was able to return to work. A significant increase in symptoms was noted on 8/14 13 with no evidence that conservative treatment has been attempted beyond a home exercise program and rest. Therefore, this request for extensor muscle slides procedure with or without an epicondylectomy.