

Case Number:	CM14-0015479		
Date Assigned:	02/28/2014	Date of Injury:	09/04/2012
Decision Date:	06/30/2014	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	02/06/2014

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 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:

The patient is a 61 year old male who was injured on 06/02/2011. The patient states that during the course of the day, he copies continuously. He has pain in the left hand and thumb. The patient underwent left thumb trigger finger release and left thumb digital block on 11/15/2013. Prior treatment history has included 10 sessions of postoperative physical therapy. EMG/NCS of the upper extremity dated 08/05/2013 revealed no electroneurographic indicators of carpal tunnel release or ulnar neuropathy were noted in the bilateral lower extremities. There is no electromyographic indicators of acute cervical radiculopathy were not noted. MRI of the cervical spine dated 07/26/2013 revealed 1) A 2-mm central protrusion at C5-C6 that effaces the ventral thecal sac with borderline encroachment on the cervical cord. There is minimal left foraminal narrowing. 2) There is a 3-mm broad-based protrusion at C6-C7 that effaces ventral thecal sac with mild impression deformity on the cervical cord. There is no stenosis, with reserved posterior CSF space. There is severe left foraminal stenosis from uncovertebral hypertrophy. Follow-up note dated 11/27/2013 indicates the patient has an exacerbation of right elbow pain. The patient is status post three lateral epicondylar injections previously with over three to four months of benefit. On exam, he has an intact incision noted over the left thumb with no signs of infection. There is some reduced range of motion noted with flexion and extension of the thumb. There is tenderness noted over the right lateral epicondyle. The patient is diagnosed with acquired trigger finger, shoulder impingement, and elbow tendonitis/bursitis. Follow-up report dated 12/26/2013 states the patient reports difficulty with his daily activities along with lifting, pushing, pulling, gripping and grasping. His right elbow was injected with cortisone which only provided him with temporary relief. He has pain and weakness that is increasing in severity. He has been unresponsive to conservative treatment along with oral pain medication. Prior UR dated 01/28/2014 states the request for a right elbow lateral release is non-certified as there is no

evidence documenting failed courses of physical therapy or findings to support functional improvement.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT ELBOW LATERAL RELEASE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM PRACTICE GUIDELINES, 2ND EDITION (REVISED 2007), CHAPTER 10 (ELBOW DISORDERS CHAPTER),

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

Decision rationale: According to the CA MTUS guidelines, surgical considerations for lateral epicondylagia are currently debatable. Conservative care should be maintained for a minimum of 3-6 months. Although some individuals will improve with surgery for lateral epicondylagia, at this time there are no published RCTs that indicate that surgery improves the condition over non-surgical options. The medical records document the patient was diagnosed with elbow tendinitis/bursitis, shoulder impingement, and acquired trigger finger. In the absence of documented failure trial of conservative treatment modalities for 3-6 months, the request is not medically necessary according to the guidelines.