

Case Number:	CM14-0110875		
Date Assigned:	08/01/2014	Date of Injury:	04/03/2014
Decision Date:	09/04/2014	UR Denial Date:	06/19/2014
Priority:	Standard	Application Received:	07/16/2014

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 Orthopaedic 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 52-year-old female administrative coordinator sustained an industrial injury on 4/3/14, relative to repetitive motion. The patient reported that she developed left elbow pain with numbness/tingling in the left ring and short fingers with computer work. Conservative treatment included physical therapy, occupational therapy, and left elbow splint. The 5/5/14 left elbow MRI demonstrated an intrasubstance tear of the common extensor tendon origin. The 6/5/14 left upper extremity electrodiagnostic study was reported normal. The 6/2/14 occupational therapy progress report indicated that the patient had completed 8/8 visits. Subjective improvement was noted in pain with activity from 8-9/10 to 5-7/10. Pain at rest was 5-6/10 and improved to 3-6/10. The Quick Dash score improved from 75 to 66. Left elbow range of motion was 12-150 degrees and improved to 0-150 degrees. Grip in elbow flexion improved from 35 to 50 pounds. The 6/11/14 treating physician report cited continued elbow discomfort with range of motion. Left elbow exam documented lateral epicondyle tenderness and pain with motion. There was no effusion present. The diagnosis was extensor carpi radialis brevis tear and left cubital tunnel syndrome. The patient was working full duty. The treatment plan included cubital tunnel night splint brace and left elbow lateral epicondyle release. The 6/19/14 utilization review denied the request for left elbow cubital tunnel night splint as there was no electrodiagnostic evidence to support the diagnosis and approval was given for an elbow splint on 5/22/14. The request for left elbow surgery was denied as guideline criteria for conservative treatment had not been completed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Elbow Lateral Epicondyle 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): 36-37.

Decision rationale: The California MTUS updated ACOEM elbow guidelines state that surgery for lateral epicondylalgia 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. However, there are unusual circumstances in which, after 3 months of failed conservative treatment, surgery may be considered. Although some individuals will improve with surgery for lateral epicondylalgia, at this time there are no published RCTs that indicate that surgery improves the condition over non-surgical options. Guideline criteria have not been met. There is no detailed documentation that comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried for 6 months and failed. The patient had undergone 2 months of conservative treatment at the time of the surgical request with some improvement documented and continued occupational therapy recommended. Therefore, this request for left elbow lateral epicondyle release is not medically necessary.

Cubital Tunnel Night Splint Brace: 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): 18-19, 41.

Decision rationale: The California MTUS updated ACOEM elbow guidelines recommend nocturnal elbow splinting for ulnar neuropathy. Guideline criteria have not been met. There is no current clinical exam documentation suggestive of cubital tunnel syndrome and electrodiagnostic testing was normal. Records indicate that an elbow splint was previously authorized. Therefore, this request for cubital tunnel night splint brace is not medically necessary.