Case Number:	CM14-0127077		
Date Assigned:	08/22/2014	**Date of Injury:**	10/27/2013
Decision Date:	09/23/2014	**UR Denial Date:**	07/11/2014
Priority:	Standard	**Application Received:**	08/11/2014

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 is a 46 year old female with a 10/27/13 injury date. The patient sustained a right elbow injury while at work after repeatedly and forcibly gripping and scanning items. She was seen on 12/20/13 for an orthopedic evaluation. Subjective complaints included right elbow pain with radiation down her arm, and tingling and numbness in digits 4/5. She reports undergoing cortisone injections for this problem in the past by [redacted]. In a more recent follow-up on 6/2/14, the patient reports that her elbow pain is 7/10 but her ADLs are maintained on medication to include grocery shopping, bathing, grooming, and household duties. Objective findings include tenderness in the right cubital tunnel and a positive Tinel's sign at the cubital tunnel, and diminished sensation distally in the ulnar nerve distribution. In a 6/30/14 follow-up, the patient reports right forearm muscle spasms that remain refractory to heat, cold, stretching, physical therapy, home exercise, and TENS unit. EMG/NCS on 1/30/14 showed only mild carpal tunnel syndrome. Diagnostic impression: right cubital tunnel syndrome.Treatment to date: medication management, stretching and home exercises, TENS unit, cold/heat.A UR decision on 7/10/14 denied the request for right cubital tunnel decompression on the basis that the clincal information provided fails to meet evidence based guidelines for the requested service.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Cubital Tunnel Decompression: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Occupational Medical Practice Guidelines, Second Edition (2004), Surgical Considerations - Elbow Disorders, page 37.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 603-606.

Decision rationale: CA MTUS criteria for cubital tunnel release include clear clinical evidence and positive electrical studies, significant loss of function, and failed conservative care; absent findings of severe neuropathy such as muscle wasting, at least 3-6 months of conservative care should precede a decision to operate. Studies show that while effective, the complication rate is higher than for simple decompression. Surgical options for this problem are high cost, invasive, and have side effects. Yet, in well-defined but infrequent cases that include positive electrodiagnostic studies with objective evidence of loss of function where at time of attempted decompression, indications are felt to be present necessitating anterior transposition, this may be a reasonable option. Submuscular transposition has not been shown to be beneficial. This surgical option for this problem is high cost, invasive, and has side effects. In the present case, there does not appear to be enough detailed evidence that all forms of conservative treatment have been diligently attempted for a period of at least 3-6 months. This would especially include nighttime extension splinting, which was not documented. Other modalities that would need more thorough documentation include full compliance in therapy, use of elbow pads, removing opportunities to rest the elbow on the ulnar groove, and workstation changes. This is especially important given the relatively high complication rate of ulnar nerve decompression. In addition, the EMG results were not consistent with cubital tunnel syndrome, and the patient appears to be obtaining some degree of benefit from her medications. At this time, the requested surgery cannot be approved. Therefore, the request for right cubital tunnel decompression is not medically necessary.

Anesthesiologist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2013, Low Back Chapter, Preoperative electrocardiogram (ECG); Preoperative testing, general.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: http://en.wikipedia.org/wiki/Anesthesiologist.

Decision rationale: CA MTUS and ODG do not address this issue. Evidence based guidelines cannot be provided because it is not clear what is meant by "anesthesiologist." A wikipedia search for "anesthesiologist" revealed the following definition. "Anesthesiologists (anaesthetists in the UK) are physicians who provide medical care to patients in a wide variety of (usually acute) situations. This includes a preoperative evaluation, consultation with the surgical team, creation of a plan for the anaesthesia tailored to each individual patient, airway management, intraoperative life support and provision of pain control, intraoperative diagnostic stabilisation,

and proper post-operative management of patients. For anesthesiologists/anaesthetists, preparation of patients for emergency surgery is mandatory and essential. Because anesthesiologists/anaesthetists are physicians, in contrast to other anesthesia providers, they are able to utilize their extensive knowledge of physiology, pharmacology and diseases to guide their decision making." However, because the primary procedure could not be certified, secondary requests cannot be approved at this time. Therefore, the request for anesthesiologist is not medically necessary.

Intrepid Anesthesia: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: http://www.manta.com/c/mr4hn5h/intrepid-anesthesia-associates-corporation.

Decision rationale: CA MTUS and ODG do not address this issue. Evidence based guidelines cannot be provided because it is not clear what is meant by "intrepid anesthesia." A google search for "intrepid anesthesia" revealed that Intrepid Anesthesia Associates Corporation is a medical group in Woodland Hills, CA. However, because the primary procedure could not be certified, secondary requests cannot be approved at this time. Therefore, the request for intrepid anesthesia is not medically necessary.

Pre-op Labs: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2013, Low Back Chapter, Preoperative electrocardiogram (ECG); Preoperative testing, general.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: American Society of Anesthesiologists Practice Advisory for Preanesthesia Evaluation.

Decision rationale: CA MTUS and ODG do not address this issue. The American Society of Anesthesiologists states that routine preoperative tests (i.e., tests intended to discover a disease or disorder in an asymptomatic patient) do not make an important contribution to the process of perioperative assessment and management of the patient by the anesthesiologist; selective preoperative tests (i.e., tests ordered after consideration of specific information obtained from sources such as medical records, patient interview, physical examination, and the type or invasiveness of the planned procedure and anesthesia) may assist the anesthesiologist in making decisions about the process of perioperative assessment and management. However, because the primary procedure could not be certified, secondary requests cannot be approved at this time. Therefore, the request for pre-op labs is not medically necessary.

EKG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2013, Low Back Chapter, Preoperative electrocardiogram (ECG); Preoperative testing, general.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): ODG (Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter-Pre operative EKG and Lab testing).

Decision rationale: CA MTUS does not address this issue. ODG states that pre-op testing can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgery who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. The ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery state that in the asymptomatic patient, a more extensive assessment of history and physical examination is warranted in those individuals 50 years of age or older. . However, because the primary procedure could not be certified, secondary requests cannot be approved at this time. Therefore, the request for EKG is not medically necessary.

History: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2013, Low Back Chapter, Preoperative electrocardiogram (ECG); Preoperative testing, general.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: American Society of Anesthesiologists Practice Advisory for Preanesthesia Evaluation.

Decision rationale: CA MTUS and ODG do not address this issue. The American Society of Anesthesiologists states that routine preoperative tests (i.e., tests intended to discover a disease or disorder in an asymptomatic patient) do not make an important contribution to the process of perioperative assessment and management of the patient by the anesthesiologist; selective preoperative tests (i.e., tests ordered after consideration of specific information obtained from sources such as medical records, patient interview, physical examination, and the type or

invasiveness of the planned procedure and anesthesia) may assist the anesthesiologist in making decisions about the process of perioperative assessment and management. However, because the primary procedure could not be certified, secondary requests cannot be approved at this time. Therefore, the request for History is not medically necessary.