

<b>Case Number:</b>	CM14-0021552		
<b>Date Assigned:</b>	05/07/2014	<b>Date of Injury:</b>	03/03/2010
<b>Decision Date:</b>	07/09/2014	<b>UR Denial Date:</b>	01/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/20/2014

### 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 45-year-old male bus driver sustained an industrial injury 3/3/10, resulting from occupational overuse syndrome. The patient is status post right shoulder arthroscopic decompression and labral repair on 1/12/11, release of carpi radialis insertion and wrist arthroscopy on 11/23/11, and debridement of the right lateral elbow with extensor origin repair on 12/5/12. The 8/9/13 left elbow MRI impression documented a normal exam. The 9/1/13 PQME reported the onset of left upper extremity compensatory overuse syndrome following the right elbow surgery, and stated that he did not recommend left elbow surgery based on the absence of any MRI pathology. The 12/26/13 treating physician report noted left elbow physical exam findings of swelling, full range of motion, tenderness at the extensor origin, and pain with resisted wrist extension. The patient had right elbow surgery with modest gains. The patient asked to seek authorization for the left lateral elbow surgery. The 1/21/14 utilization review denied the request for left elbow surgery based on lack of specific information relative to mechanism of injury, marginal findings on physical exam, modest success with prior surgical interventions, the assertion that this request was at the behest of the patient, and insufficient clinical data presented to support surgical intervention. The 4/7/14 treating physician report cited subjective complaints of grade 4-9/10 left elbow pain on the dorsal and ulnar side, made worse with motion and resisted activity, and weakness. Left elbow pain was progressive since 2011, and present at night. A left elbow corticosteroid injection on 6/18/13 provided no relief. He attempted 3 to 4 therapy treatments but the "pain was too unbearable". The left upper extremity exam documented normal range of motion, no obvious deformity, lateral elbow pain with resisted wrist extension, and 4/5 giving way strength secondary to pain with biceps and triceps. There was maximal tenderness noted over the lateral epicondyle, posterolateral joint, radiocapitellar joint, medial epicondyle, and triceps tendon. The bilateral elbow x-rays showed

no obvious bony abnormality. The diagnosis was lateral epicondylitis and elbow joint pain with normal x-rays. A left elbow arthroscopic release was recommended.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **LEFT LATERAL ELBOW DEBRIDEMENT WITH EXTENSOR ORIGIN REPAIR:**

Upheld

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

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

**Decision rationale:** Under consideration is a request for left lateral elbow debridement with extensor origin repair. 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. Guideline criteria have been met. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried consistent with guidelines for over 3 months and had failed. Left elbow surgery is also not supported due to the absence of any significant MRI-associated pathology. Therefore, this request for left lateral elbow debridement with extensor origin repair is not medically necessary.