

<b>Case Number:</b>	CM14-0022550		
<b>Date Assigned:</b>	02/26/2014	<b>Date of Injury:</b>	10/31/2011
<b>Decision Date:</b>	08/06/2014	<b>UR Denial Date:</b>	02/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/24/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 records presented for review indicate that this 40-year-old male was reportedly injured on 10/31/2011. The mechanism of injury was not listed in the records reviewed. The most recent progress note, dated 12/4/2013, indicates that there were ongoing complaints of left shoulder, bilateral elbows, right hand/wrist, low back, right knee, right foot and ankle pains. The physical examination demonstrated right elbow tenderness to palpation over the lateral epicondyle. Right hand/wrist numbness was noted in the third and fourth fingers of the right hand. Diagnostic studies included an electrodiagnostic (EMG/NCS) study of the upper extremity on 8/3/2013, which revealed right carpal tunnel syndrome and right ulnar neuropathy. Previous treatment included Norco and Ambien. A request was made for right elbow lateral epicondylar debridement and repair, pre-operative labs and postoperative use of cold therapy unit for 10 days and was not certified in the pre-authorization process on 2/11/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RIGHT ELBOW LATERAL EPICONDYLAR DEBRIDEMENT AND REPAIR:** 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: California Guidelines: Elbow Disorders-Surgical Considerations.

**Decision rationale:** CA MTUS guidelines support surgical intervention for chronic lateral epicondylalgia in select clinical settings for individuals, who fail to improve after a minimum of six months of care and have included at least 3 or 4 different types of conservative intervention. After review of the medical documentation provided, there was insufficient evidence to show failure of conservative treatment as well as solid objective clinical documentation substantiating the need for the above requested procedure. Therefore, this request is deemed not medically necessary.

**PRE-OPERATIVE LABS:** 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 Official Disability Guidelines (ODG): ODG online (<http://www.odg-twc.com/>) Pain (Chronic).

**Decision rationale:** Preoperative lab work is not found in MTUS Guidelines, therefore Official Disability Guidelines (ODG) were used. The routine suggests monitoring package inserts for preoperative patients and recommends lab monitoring of a complete blood count (CBC) and chemistry profile (including liver and renal function tests). After review of the medical documentation, the above requested surgical procedure has not been approved. Therefore, there is no need for preoperative lab work to be performed at this time. This request is deemed not medically necessary.

**POST-OPERATIVE USE OF COLD THERAPY UNIT FOR 10 DAYS:** 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 Official Disability Guidelines (ODG): TWC - Shoulder (Acute & Chronic)(updated 04/25/14) - Continuous Flow Cryotherapy.

**Decision rationale:** Cryotherapy units are recommended as an option after surgery but not for nonsurgical treatment. Postoperative use generally may be up to seven days, including home use. After review of the medical documentation provided, the requested surgical procedure has not been determined to be medically necessary. Therefore, the request for cryotherapy is deemed not medically necessary.