

<b>Case Number:</b>	CM14-0043259		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	04/18/2011
<b>Decision Date:</b>	08/22/2014	<b>UR Denial Date:</b>	03/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/17/2014

### 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 20-year-old who sustained a vocational injury to his left upper extremity on April 18, 2011 when he fell off a truck. The records provided for review document that the claimant has undergone multiple surgeries after his initial open reduction and internal fixation of the left radial head with pinning of the distal radius following the injury. On June 10, 2011, the claimant underwent removal of hardware and fluoroscopic evaluation of the left elbow. On December 1, 2011, the claimant underwent a left flexor carpi radialis extensor digitorum communis tendon transfer and a left palmaris longus rerouted extensor palmaris longus tendon transfer with removal of a left elbow retained suture. The report of an MRI of the left elbow dated July 30, 2013, showed postoperative changes laterally from reconstruction with irregularity of the radial collateral ligament proximally, suspicious for tearing involving the volar component of the ligamentous complex. There were also early degenerative/arthritis changes primarily affecting the radial aspect of the elbow with chondral loss and osteophytic ridging. Then on October 9, 2013, the claimant underwent a left pronator teres extensor tensor carpi radialis tendon transfer, tenolysis of the previous left palmaris longus to extensor palmaris longus tendon transfer with tendon imbrication and revision of the scar greater than 10 centimeters. The report of a CT of the left upper extremity/elbow dated January 27, 2014 showed a healed internally fixated radial head fracture with 1 millimeter of articular incongruence, healed fracture of the capitellum, a 9 millimeter loose body in the anterior recess, mild ulnar humeral and proximal radial and ulnar joint osteoarthritis, heterotopic ossification in the common flexion wad from an old injury. On April 11, 2014, the claimant underwent a left elbow operative arthroscopy, with extensive debridement, proximal radial ulnar joint chondroplasty, and a rotation contracture release. The report of the office visit on June 25, 2014, noted that the claimant was two and a half months status/post his most recent surgical intervention with left elbow and forearm pain. Physical

examination revealed that arthroscopic incisions were healed with slight swelling and tenderness but no evidence of infection, range of motion was 10 degrees of extension to 125 degrees of flexion, 70 degrees of pronation, 40 degrees of supination, wrist showed full range of motion, and limited active wrist and thumb extension. The ulnar and motor nerves were completely intact and motor and sensory examination of the left upper extremity was within normal limits. X-rays taken in the office that day showed two screws in the radial head that were fixed anatomically, multiple bone fragments in the area of the cubital tunnel, slight irregularity in the radial joint, and evidence of minimal heterotopic ossification formation in the radial ulnar and radial capitellar joints. It was documented that conservative treatment to date included extensive postoperative physical and occupational therapy following each of the previous five surgeries, progression to a home exercise program, and anti-inflammatories. The claimant's working diagnosis included status post ORIF (open reduction and internal fixation) of left radial head, status post pinning of left distal radius, left elbow stiffness and pain with heterotopic ossification, status post tendon transfers with radial nerve injury, wrist and thumb extension weakness, status post left pronator teres extensor carpi radialis tendon transfer and tenolysis of previous left palmaris longus to extensor palmaris longus tendon transfer with tendon imbrication, status post left elbow arthroscopic debridement, proximal radial joint chondroplasty, rotation contracture release and postop radiation therapy. The current request is for spur excision, contracture release, possible arthrotomy, and possible radial head excision under axillary block.

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

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

**Spur excision, contracture release, possible arthrotomy, possible radial head excision under axillary block:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Wheelless' Textbook of Orthopaedics, Excision of radial head.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 44-49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Elbow chapter - Radial Head fracture Radial head fracture surgery and Other Medical Treatment Guideline or Medical Evidence: Wheelless Textbook of Orthopedics, online: Elbow Flexion Contracture / Stiff Elbow.

**Decision rationale:** California ACOEM Elbow Updates, the Official Disability Guidelines and the Wheelless Textbook of Orthopedics Online do not support the request for spur excision, contracture release, possible arthrotomy and possible radial head excisions of the elbow under axillary block. The Official Disability Guideline and Wheelless Textbook of Orthopedics Online support surgical intervention for radial head fractures and subsequent excision only in the setting of type III and in rare cases type IV fractures. In this case, at the time of the surgical request, the claimant was only two and one-half months from the most recent surgical intervention. The documentation since that surgery does not suggest that the claimant has reached maximal medical improvement from the most recent surgical intervention. Wheelless' Textbook of Orthopedics Online notes that most surgeons do not proceed with surgery until the claimants

have undergone at least twelve weeks of physical therapy and have been at least five months out from the most recent surgical intervention. There is a lack of documentation that the claimant has attempted a turn buckle splint in which may patients experience a 30 degree increase in elbow range of motion over a period of five months. There is no documentation of instability of the elbow and physical exam findings fail to suggest that there is a loose body causing impingement of the joint. There is a lack of diagnostic testing since the most recent surgical intervention since April 11, 2014 confirming that a loose body is present. Loose bodies previously identified in the CT scan of January 27, 2014, preceded the most recent surgery and it is not clear if it was addressed at the time of surgical intervention or, if it was not, the reason for not addressing it during the April surgery. Therefore, based on the documentation presented for review and in accordance with California ACOEM, Official Disability Guidelines, Wheelless Text of Orthopedics Online, the request for spur excision, contracture release, possible arthrotomy and possible radial head excisions of the elbow under axillary block cannot be considered medically necessary.

**Left elbow operative arthroscopy, extensive debridement, loose body removal:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, Radial head fracture surgery.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 44-49. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Wheelless Textbook of Orthopedics, online: Elbow Flexion Contracture / Stiff Elbow.

**Decision rationale:** In regards to the second request for left elbow operative arthroscopy, extensive debridement, loose body removal, the prior surgical intervention was deemed not medically necessary for spur excision, contracture release, possible arthrotomy, and possible radial head excisions under axillary block. In this case, at the time of the surgical request, the claimant was only two and one-half months from the most recent surgical intervention. The documentation since that surgery does not suggest that the claimant has reached maximal medical improvement from the most recent surgical intervention. Wheelless' Textbook of Orthopedics Online notes that most surgeons do not proceed with surgery until the claimants have undergone at least twelve weeks of physical therapy and have been at least five months out from the most recent surgical intervention. There is a lack of documentation that the claimant has attempted a turn buckle splint in which may patients experience a 30 degree increase in elbow range of motion over a period of five months. For these same reasons, the request for left elbow operative arthroscopy, extensive debridement, and loose body removal cannot be considered medically necessary.

