

Case Number:	CM14-0050328		
Date Assigned:	06/25/2014	Date of Injury:	09/15/2011
Decision Date:	08/05/2014	UR Denial Date:	03/10/2014
Priority:	Standard	Application Received:	03/25/2014

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 40-year-old female sustained an industrial injury on 9/15/11. Surgical history was positive for right elbow surgery in 2002. The 6/12/13 upper extremity EMG/NCV documented mild carpal tunnel syndrome. She underwent right shoulder subacromial decompression, acromioclavicular joint excision and carpal tunnel release on 7/17/13. The 11/18/13 right elbow MRI impression documented two suture anchors in place within the lateral humeral epicondyle. The common extensor tendon origin demonstrated mild thickening with small areas of superficial fraying which may represent a chronic/post-operative appearance. There was no evidence for abnormal signal or discrete significant partial or full thickness tearing. Otherwise, normal appearance of the imaged tendons about the elbow with normal marrow signal. The 2/21/14 treating physician report cited severe and worsening right elbow pain. Right elbow exam findings documented tenderness over the lateral epicondyle, mobile wad of three, intact sensation, positive radial and ulnar pulses, good reflexes, good strength, no instability, pain with resisted wrist extension, and pain with pronation grip test. Neurologic tests showed no compressive peripheral neuropathy. Right elbow active range of motion was -35 degrees extension, 110 degrees flexion, and 40 degrees supination/pronation. The treating physician documented that the patient had failed conservative treatment including non-steroidal anti-inflammatory drugs (NSAIDs), injection, steroids, therapy, and time. The treating physician stated that the physical therapist had tried to work on the elbow while the shoulder was under therapy but she could not tolerate physical therapy to the elbow. The treatment plan recommended lateral epicondylar reconstruction with scope. The 3/10/14 utilization review denied the request for right elbow surgery and post-operative physical therapy based on failure to meet guideline criteria for surgery. There was an absence of electrodiagnostic evidence of an

entrapment neuropathy and no documentation of conservative treatment directed to the right elbow in the past 12 months.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Right lateral epicondylar reconstruction, R elbow arthroscopy with debriment: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 34-36.

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. The Official Disability Guidelines recommend lateral epicondylar surgery limited to severe entrapment neuropathies. Criteria require 12 months of compliance with non-operative management, including physical therapy exercise programs to increase range of motion and strength of the musculature around the elbow. Criteria also include long term failure of at least one type of injection, ideally with documented short-term relief from injection. Guideline criteria have not been met. The patient presents with severe pain and marked loss of right elbow range of motion. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried consistent with guidelines for over 6 months and have failed. Non-steroidal anti-inflammatory drugs have been prescribed over the past year. Oral steroids were prescribed of 10/23/13. Splinting has been reported since 4/23/13. There is no documentation of an elbow injection or a directed course of physical therapy for the elbow. Left elbow surgery is also not supported by the absence of a MRI documented surgical lesion or evidence of severe entrapment neuropathy. Therefore, the request for right lateral epicondylar reconstruction, right elbow arthroscopy with debridement is not medically necessary.

12 Post-op Physical Therapy Sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 17.

Decision rationale: As the request for right lateral epicondylar reconstruction, right elbow arthroscopy with debridement is not medically necessary, the request for 12 post-op physical therapy sessions is also not medically necessary.

