

Case Number:	CM14-0077215		
Date Assigned:	07/18/2014	Date of Injury:	10/29/2013
Decision Date:	08/15/2014	UR Denial Date:	05/16/2014
Priority:	Standard	Application Received:	05/27/2014

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 52-year-old male sustained an industrial injury on 10/29/13. Injury occurred while moving a swamp cooler weighing approximately 100 pounds. His right arm gave out, went numb and he experienced onset of pain. Past surgical history was positive for right elbow tenotomy debridement and repair in May 2013. The 11/14/13 right elbow MRI impression documented post-surgical changes and was otherwise normal. Progress reports on 1/27/14, 2/21/14, and 3/4/14 indicated that the patient had neck pain with recommendations for cervical MRI and follow-up noted with his private physician. The patient was noted to be status post right elbow surgery with continued lateral elbow pain post-operatively. The 2/6/14 right upper extremity EMG/nerve conduction study demonstrated mild carpal tunnel syndrome. There was no electrophysiologic evidence of ulnar neuropathy, radiculopathy, or polyneuropathy of the right arm. The 3/27/14 orthopedic consult report documented regional right elbow tenderness and positive raised abduction test. Tendon signs were positive. Ulnar and radial nerve compression signs were negative. Sensation was normal. Grip strength was 80 pounds right and 100 pounds left. The diagnosis was right cubital tunnel syndrome, right radial tunnel syndrome, and possible recurrent right lateral epicondylitis. Conservative treatment and surgical options were discussed. A cortisone injection was provided to the right radial tunnel and a cubital comfort brace was dispensed. The 5/8/14 orthopedic report cited continued intermittent numbness mostly in the ulnar 2 digits, alternating with the radial 3 digits. The radial tunnel injection provided no relief, but now he had lateral epicondyle pain and tenderness. He woke every 2 hours with pain, numbness and tingling. Physical exam documented right lateral epicondyle and radial tunnel tenderness. Right resisted wrist extension and forearm supination were positive. Right finger extension was negative. Right cubital tunnel Tinel's and ulnar nerve subluxation were negative. Direct compression and hyperflexion tests were positive. Right carpal tunnel exam demonstrated

negative Tinel's, positive direct compression, and positive Phalen's tests. The patient was frustrated with no relief despite one month of bracing and the radial tunnel cortisone injection. Surgery was requested including right revision lateral epicondylectomy, tendon debridement, and reattachment, radial tunnel release, cubital tunnel release, and possible medial epicondylectomy. The 5/16/14 utilization review denied the request for right elbow surgery and associated physical therapy based on lack of electrodiagnostic evidence of cubital tunnel syndrome, no documentation that conservative treatment was exhausted, and inconsistent exam findings. The 5/23/14 appeal letter cited full compliance to at least 3 months of conservative treatment, with failure of physical therapy, cubital tunnel splinting, cortisone injections and rest. The patient had significant symptoms with functional limitations precluding work. Muscle atrophy was reported as the biceps and forearm circumference had reduced 0.5 cm since March. The denial of the right ulnar nerve entrapment surgery was appealed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right radial tunnel release: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Elbow Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 38.

Decision rationale: The California MTUS updated ACOEM elbow guidelines state that surgery for radial nerve entrapment requires establishing a firm diagnosis on the basis of clear clinical evidence. If the patient fails at least 3 to 6 months of conservative treatment, surgery may be a reasonable option if there is unequivocal evidence of radial tunnel syndrome including positive electrodiagnostic studies and objective evidence of loss of function. Guideline criteria have not been met. There is no clear clinical evidence of radial nerve entrapment. Electrodiagnostic studies were negative. Radial tunnel injection produced no benefit. Multiple nerve compressions are reported in the right upper extremity without consistent orthopedic findings. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried for 6 months and failed. Therefore, this request for right radial tunnel release is not medically necessary.

Right cubital tunnel release, possible medial epicondylectomy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine Guidelines (2007), Ulnar Nerve Entrapment, pages 36-38; Official Disability Guidelines - Elbow Chapter; Official Disability Guidelines, Indications for Surgery.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 36-37.

Decision rationale: The California MTUS guidelines state that surgery for ulnar nerve entrapment requires establishing a firm diagnosis on the basis of clear clinical evidence and positive electrical studies that correlate with clinical findings. A decision to operate requires significant loss of function, as reflected in significant activity limitations due to the nerve entrapment and that the patient has failed conservative care, including full compliance in therapy, use of elbow pads, removing opportunities to rest the elbow on the ulnar groove, workstation changes (if applicable), and avoiding nerve irritation at night by preventing prolonged elbow flexion while sleeping. Absent findings of severe neuropathy such as muscle wasting, at least 3-6 months of conservative care should precede a decision to operate. Guideline criteria have not been met. There is no clear clinical evidence of ulnar nerve entrapment. Electrodiagnostic studies were negative. Multiple nerve compressions are reported in the right upper extremity without consistent orthopedic findings. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried for 6 months and failed. Global upper extremity atrophy is suggested which is not consistent with ulnar neuropathy. Therefore, this request for right radial tunnel release is not medically necessary.

Post-operative Occupational Therapy 2x6: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 17-18.

Decision rationale: As the request for right elbow surgery is not medically necessary, the associated request for post-operative occupational therapy 2x6 is also not medically necessary.

Right revision lateral epicondylectomy, tendon debridement, and reattachment: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine Guidelines (2007), Surgical Considerations for Lateral Epicondylalgia, pages 35-36; Official Disability Guidelines - Elbow Chapter, Criteria for Lateral Epicondylar Release for Chronic Lateral Epicondylalgia.

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

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. Guideline criteria have not been met. Right elbow MRI findings are reported normal. Exam findings suggest progressive tenderness over the right lateral epicondyle and radial tunnel. Provocative tendon signs are equivocal. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic

conservative treatment had been tried for 6 months and failed. Therefore, this request for right revision lateral epicondylectomy, tendon debridement, and reattachment is not medically necessary.