

<b>Case Number:</b>	CM14-0078126		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	10/09/2012
<b>Decision Date:</b>	08/14/2014	<b>UR Denial Date:</b>	05/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	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 female behavioral aide sustained an industrial injury on 10/9/12. Injury occurred when a consumer body slammed into her elbow, causing it to hit a metal pole and become trapped between the consumer's body and pole. Cortisone allergy was noted in the records. The 8/14/13 electrodiagnostic report documented evidence of mild median sensory neuropathy at the right carpal tunnel. There was no evidence of right ulnar neuropathy or any other neuropathic or myopathic process. The 9/5/13 right elbow MRI impression documented contusion of the coronoid without fracture. There was moderate tendinosis of the origin of the common extensor tendon and edema along the distal insertion of the brachialis tendon (low grade sprain). There was a 6 mm intra-articular body noted posteriorly, within the olecranon fossa. The 1/8/14 radial right elbow x-rays showed a 1 cm x 2 cm radial dense body in the lateral elbow that may be consistent with a loose body. The 5/12/14 utilization review denied the request for right elbow surgery as there was negative electrodiagnostic evidence for radial nerve compression, no documentation of steroid injection, and no elbow locking to support loose body removal. The 6/18/14 treating physician report cited daily right elbow, forearm and finger symptoms at rest and with activity. Chief complaint was lateral elbow pain with burning pain radiating along the dorsal forearm to the dorsal forearm and wrist. The patient had significant sensitivity at the medial elbow at the cubital tunnel/ulnar nerve with frequent paresthesias to the little and ring fingers. There was constant subjective little finger numbness. The patient also reported occasional very sharp pain at the elbow and had to shake it out, acting like a loose body caught in the joint resulting in locking. Right elbow exam documented very significant tenderness over the lateral epicondyle with wrist extension resistance, exquisite tenderness over the radial nerve at the arcade of Frohse. Tinel's was positive at the radial nerve. There was full range of motion with significant discomfort at full flexion, and slope paresthesias to the little finger over 30 seconds. Tinel's was positive at the cubital tunnel. Two point discrimination was

decreased in the little finger, greater than 8 mm. There was 5-/5 intrinsic and thenar strength with no atrophy. There was slightly positive Tinel's at the carpal tunnel. Grip strength was 3/2/5 kg right (dominant) and 15/11/10 kg left. The patient had been refractory to chronic right tennis elbow with radial neuritis/entrapment. She continued to have difficulty with activities of daily living. Comprehensive conservative treatment had been documented over nearly 2 years without improvement. Surgery was again recommended.

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

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

#### **Right Elbow Arthroscopy/Evaluation of potential loose body: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 603-606. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow, Humeral fracture surgery.

**Decision rationale:** The California MTUS does not provide specific recommendations for loose body removal surgery. The Official Disability Guidelines recommend surgical removal of loose bodies. Guideline criteria have been met. There is radiographic and imaging evidence of a loose body consistent with clinical exam findings and history of trauma. Therefore, this request for right elbow arthroscopy/evaluation of potential loose body is medically necessary.

#### **Nirschl procedure lateral epicondyle: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 603-606. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow Chapter.

**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 been met. Records documented failure of comprehensive conservative treatment over more than one year. Cortisone allergy is noted in the records. There is imaging evidence of moderate tendinosis consistent with clinical exam findings. Significant functional impairment has been documented. Therefore, this request for Nirschl procedure lateral epicondyle is medically necessary.

## **Decompress of radial nerve at arcade of Frohse: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 603-606. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow Chapter.

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

**Decision rationale:** Surgery for radial nerve entrapment requires establishing a firm diagnosis on the basis of clear clinical evidence. Positive electrical studies that correlate with clinical findings should be present. 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, and workstation changes (if applicable). 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 been met. There is consistent exam evidence of radial nerve entrapment that has failed to respond to comprehensive conservative treatment greater than 6 months. Significant functional impairment is documented. Therefore, this request for decompression of radial nerve at arcade of Frohse is medically necessary.

## **Occupational Therapy x 6: Overturned**

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

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

**Decision rationale:** The California Post-Surgical Treatment Guidelines for lateral epicondylitis suggest a general course of 12 post-operative physical medicine visits over 12 weeks. The post-surgical treatment period was defined as 6 months. An initial course of therapy would be supported for one-half the general course or 6 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical period. Guideline criteria have been met for initial post-op therapy. Therefore, this request for occupational therapy x 6 visits is medically necessary.

**Pre-op clearance appt. w/Internal Med to include EKG, Labs, CXR as indicated:**  
Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice Advisory for Preanesthesia Evaluation-American Society of Anesthesiologists Task Force on Pre-anesthesia Evaluation

**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: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3): 522-38; ACR Appropriateness Criteria® routine admission and preoperative chest radiography. Reston (VA): American College of Radiology (ACR); 2011. 6 p.

**Decision rationale:** The California MTUS do not provide recommendations for these services. Evidence based medical guidelines support the use of pre-operative medical clearance for patients undergoing surgical procedures. Guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. Routine chest x-ray is not recommended except when acute cardiopulmonary disease is suspected on the basis of history and physical examination. An EKG may be indicated for patients with known cardiovascular risk factors or for patients with risk factors identified in the course of a pre-anesthesia evaluation. Guideline criteria have been met. This patient is a middle aged female with a history of asthma. She is an occasional smoker. Middle-aged females have known occult increased cardiovascular risk factor to support the medical necessity of a pre-operative medical clearance and pre- procedure EKG. Given the patient's respiratory illness and smoking status, chest x-ray is reasonable. Basic lab studies would be appropriate as indicated by the pre-op clearance. Therefore, this request for pre-op clearance appointment with Internal Medicine, to include EKG, labs, chest x-ray as indicated, is medically necessary.