

Case Number:	CM14-0199075		
Date Assigned:	12/09/2014	Date of Injury:	11/12/2013
Decision Date:	01/23/2015	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	11/26/2014

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, has a subspecialty in Surgery of the Hand and is licensed to practice in Hawaii. 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 injured worker is a 59-year-old female who reported an injury on 11/12/2013. The mechanism of injury was not provided. Diagnoses included lateral epicondylitis of the left. Past treatments included surgery, injections, physical therapy, and home exercise program. Diagnostic studies included an unofficial MRI performed on 08/28/2014 which indicated no evidence of acute tear, edema, or fluid collection. The common extensor tendon demonstrated high signal intensity on fluid sensitive sequences near its proximal attachment at the lateral epicondyle. An official electrodiagnostic test performed on 09/02/2014, read by [REDACTED], MD, which indicated abnormalities suggestive of mild/early left carpal tunnel syndrome, no evidence for left ulnar/radial neuropathy or polyneuropathy. Surgical history included left elbow lateral epicondyle revision and partial ostectomy on 11/12/2014. On the clinical note dated 12/04/2014, the injured worker complained of improved lateral elbow pain since surgery; however, pain at the antecubital was worsened when twisting her arm. The injured worker also indicated increased tingling in her thumb. Physical examination indicated range of motion 20 to 140 degrees of the left elbow and neurovascularly intact. Current medications were not provided. The request was for lateral epicondyle revision with partial ostectomy and left wrist endoscopic carpal tunnel release. The rationale for the request was not provided. The Request for Authorization form was submitted for review on 10/06/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Wrist Endoscopic Carpal Tunnel Release: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome, Carpal tunnel release surgery (CTR)

Decision rationale: The request for left wrist endoscopic carpal tunnel release is not medically necessary. The California MTUS/ACOEM Guidelines state surgical decompression of the median nerve usually relieves carpal tunnel syndrome symptoms. The Official Disability Guidelines recommend carpal tunnel release surgery after an accurate diagnosis of moderate or severe carpal tunnel syndrome. Indications for surgery include muscle atrophy, severe weakness of thenar muscles, 2 point discrimination test greater than 6 mm, and positive electrodiagnostic testing. The medical records indicate the patient has increased tingling in her thumb. The medical records indicate an official EMG to have been performed on 09/02/2014, indicating mild/early left carpal tunnel syndrome. However, there is a lack of documentation indicating muscle atrophy, severe weakness of thenar muscles, and 2 point discrimination test of greater than 6 mm. Therefore, the request for left wrist endoscopic carpal tunnel release is not medically necessary.

Lateral Epicondyle Revision with Partial Osteotomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 44-45. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow, Surgery for epicondylitis

Decision rationale: The request for lateral epicondyle revision with partial osteotomy is not medically necessary. The California MTUS/ACOEM Guidelines state there is currently a debate regarding whether lateral epicondylalgia is an inflammatory condition or an enthesopathy and what treatments are most appropriate. Official Disability Guidelines recommend for chronic lateral epicondylitis after 12 months of failed conservative treatment. Criteria for lateral epicondylar release state limit to severe entrapment neuropathies, over 95% recovery with conservative treatment; 12 months of compliance with non-operative management: failure to improve with NSAIDs, elbow bands/straps, activity modification, and physical therapy exercise programs and long term failure with at least 1 type of injection, ideally with documented short term relief from the injection. The medical records indicate the injured worker is status post left elbow lateral epicondyle revision and partial osteotomy on 11/12/2014. The medical records indicate the patient has range of motion from 20 to 140 degrees and is neurovascularly intact. The injured worker complained of antecubital pain that is made worse with twisting of her arm. However, there is a lack of documentation indicating the rationale for the procedure to be performed a second time. There is a lack of documentation indicating 12 months of compliance with non-operative management. There is a lack of documentation indicating short term relief

from the injections. Therefore, the request for lateral epicondyle revision with partial ostectomy is not medically necessary.