

<b>Case Number:</b>	CM15-0137351		
<b>Date Assigned:</b>	07/27/2015	<b>Date of Injury:</b>	08/01/2014
<b>Decision Date:</b>	08/25/2015	<b>UR Denial Date:</b>	06/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/15/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 injured worker is a 55-year-old female who sustained an industrial injury on 8/01/14, relative to repetitive work activities. Conservative treatment included oral and topical anti-inflammatory medications, bracing, platelet-rich plasma injection, activity modification, and Flector patches. The 6/22/15 treating physician report cited waxing and waning symptoms. She was unable to fully use her right arm due to right outer elbow pain. She continued to have numbness and tingling, and pain in the left thumb interphalangeal joint, which was sometimes difficult to move. She was wearing a lateral epicondyle brace during the day. Physical exam documented tenderness at the right lateral epicondyle, more at the anterior aspect, and minimal tenderness in the distal extensor muscle. Carpal tunnel provocative testing was positive with reported electrodiagnostic findings of mild right carpal tunnel syndrome. There were no ulnar-sided findings. Pressure on both ulnar nerves at the elbow did not cause any radiating tingling distally. The diagnosis was persistent right lateral epicondylitis, right carpal tunnel syndrome, and history of right ulnar neuritis. Surgery was recommended for the right lateral epicondyle and Nirschl-type procedure to excise the scar tissue and offer a better chance at healing than what happened the first time. The treatment plan included a right wrist brace for nighttime use, and right carpal tunnel steroid injection. Authorization was requested for surgery for right lateral epicondylitis. The 6/29/15 utilization review non-certified the request for surgery for right lateral epicondylitis based on an absence of clinical information regarding the prior surgery. The 7/20/15 treating physician appeal letter stated that the patient did not have previous right lateral epicondyle surgery. Physical exam documented considerable tenderness over the right lateral

epicondyle and a cystic fell about 1.2 cm that was very tender. Resisted long finger extension and fist dorsiflexion increased pain at the right lateral epicondyle. She remained off work as modified duty was not available. Authorization for right lateral epicondylitis surgery was requested.

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

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

#### **1 Surgery for Right elbow Lateral epicondylitis: Overturned**

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

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

**Decision rationale:** The California MTUS 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. Although some individuals will improve with surgery for lateral epicondylalgia, at this time there are no published RCTs that indicate that surgery improves the condition over non-surgical options. Guideline criteria have been met. This injured worker presents with persistent and function-limiting right elbow pain. Pain precludes return to work. Clinical exam findings are consistent with lateral epicondylitis. Detailed evidence of at least 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.