

Case Number:	CM15-0193696		
Date Assigned:	10/07/2015	Date of Injury:	01/16/2013
Decision Date:	11/18/2015	UR Denial Date:	09/28/2015
Priority:	Standard	Application Received:	10/02/2015

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: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 56 year old female who reported an industrial injury on 1-16-2013. Her diagnoses, and or impressions, were noted to include: a history of accumulative trauma to the bilateral upper extremities; cubital tunnel and carpal tunnel release of the left elbow-wrist, with cubital and carpal tunnel syndromes; and left elbow epicondylitis with high grade partial tendon tear. No current imaging studies were noted. Her treatments were noted to include: an agreed medical examiners supplemental report on 6-12-2015; a sleep study on 10-20-2014, noting need for inpatient surgery; and rest from work. The progress notes of 9-2-2015 reported: an orthopedic re-evaluation of her left elbow and noting her left elbow open lateral epicondylar debridement surgery had first been delayed for 3 months by the pre-operative Ears-Nose-Throat (ENT) examination, followed by further delay from sinus infection and heart palpitations, and resulting in the ENT physician recommending that she required inpatient surgery due to needing special anesthesia. The objective findings were noted to include a continued worsening of her left elbow. The physician's requests for treatment were noted to include a request for evaluation and treatment of the left elbow by a specific inpatient orthopedic surgeon. No Request for Authorization for an inpatient evaluation with an orthopedic surgeon. The Utilization Review of 9-28-2015 non-certified the request for an inpatient evaluation and treatment with a specialist surgeon.

IMR ISSUES, DECISIONS AND RATIONALES

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

Evaluate and treat with specialist for in-patient surgeon: Upheld

Claims Administrator guideline: Decision based on MTUS Elbow Complaints 2007, Section(s): Lateral Epicondylalgia. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow (Acute & Chronic): Surgery for epicondylitis.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, and Shoulder Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: Per the MTUS Guidelines, the clinician acts as the primary case manager. The clinician provides medical evaluation and treatment and adheres to a conservative evidence-based treatment approach that limits excessive physical medicine usage and referral. The clinician should judiciously refer to specialists who will support functional recovery as well as provide expert medical recommendations. Referrals may be appropriate if the provider is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or agreement to a treatment plan. Per the MTUS guidelines, there is currently a debate regarding whether lateral epicondylalgia is an inflammatory condition or an enthesopathy and what treatments are most appropriate. Conservative care should be maintained for a minimum of 3-6 months. 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. There are clinical trials to compare different surgical techniques, but this type of study cannot show the benefit of surgical intervention over medical treatment or untreated controls, particularly when numerous studies have documented the tendency for the condition to spontaneously improve over time. 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. In this case, the injured worker had a previous left elbow open lateral epicondylar debridement surgery and is now having continued worsening of her left elbow. The first attempt at elbow surgery did not appear to help the injured worker and there is a lack of evidence of attempts at conservative treatments after the surgery, therefore, the request to evaluate and treat with specialist for in-patient surgeon is not medically necessary.