

Case Number:	CM15-0214004		
Date Assigned:	11/03/2015	Date of Injury:	06/24/2013
Decision Date:	12/31/2015	UR Denial Date:	10/09/2015
Priority:	Standard	Application Received:	10/30/2015

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: Minnesota, Florida
 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 is a 37-year-old female who sustained a work-related injury on 6-24-13. The injured worker was treated for status post right shoulder subacromial decompression and biceps release, right radial tunnel syndrome, right lateral epicondylitis, and right medial epicondylitis. On 9-30-15, she was just over 8 months status post right shoulder subacromial decompression and biceps release. She completed at least nine sessions of post-operative therapy and was 8 weeks status post a 2nd cortisone injection to the lateral epicondyle with recurrent pain. She reported right shoulder pain 1-5 and dull with use. Her lateral epicondylitis and radial tunnel pain were 3-5 and dull with use. Her medial epicondylitis was "ok." Objective findings included good range of motion of the shoulder and good strength. She had increased tenderness to palpation in the radial tunnel and tenderness over the lateral epicondyle. She had tenderness in the area of the medial epicondyle. Previous conservative therapy included physical therapy, injections, bracing and NSAIDS. A request for right lateral and medial epicondylectomy with fasciotomy, tendon debridement, reattachment, ulnar nerve decompression of the elbow and radial tunnel release under regional block on an outpatient basis was received on 10-2-15. On 10-9-15, the Utilization Review physician modified right lateral and medial epicondylectomy with fasciotomy, tendon debridement, reattachment, ulnar nerve decompression of the elbow and radial tunnel release under regional block on an outpatient basis to right lateral epicondylectomy with fasciotomy, tendon debridement, reattachment, under regional block on an outpatient basis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right lateral and medial epicondylectomy with fasciotomy, tendon debridement, reattachment, ulnar nerve decompression of the elbow and radial tunnel release under regional block on an outpatient basis: Upheld

Claims Administrator guideline: Decision based on MTUS Elbow Complaints 2007, Section(s): Ulnar Nerve Entrapment. Decision based on Non-MTUS Citation Official Disability Guidelines, Elbow Chapter, Surgery for Epicondylitis.

MAXIMUS guideline: Decision based on MTUS Elbow Complaints 2007, Section(s): Ulnar Nerve Entrapment, Radial Nerve Entrapment, Lateral Epicondylalgia, Medial Epicondylalgia.

Decision rationale: A progress report from September 2, 2015 indicates that the injured worker was 7-1/2 months post right shoulder surgery and was being followed for right elbow and thumb issues. She had received 2 corticosteroid injections to the lateral epicondyle and had finished therapy. The subjective complaints included right shoulder pain 1/5, right lateral epicondylitis pain 1/5, radial tunnel pain 1/5 and medial epicondylitis and thumb were okay. On examination she had good range of motion of the shoulder. There was slight tenderness over the radial tunnel, slight pain with resisted active extension of the middle finger and resisted supination but not passive pronation of the forearm and slight tenderness over the lateral epicondyle, slight pain with resisted active extension of the wrist and no tenderness in the area of the medial epicondyles and none in the thumb. The documentation submitted includes EMG and nerve conduction studies dated 2/28/2014 at which time she had shoulder pain radiating down the right upper extremity to the hand and fingers associated with swelling in the hand. The EMG and nerve conduction studies were all within normal limits. In particular, there is no electrodiagnostic evidence of cubital tunnel syndrome or radial tunnel syndrome documented. The utilization review has certified the requested epicondylectomy and fasciotomy of the lateral epicondyle with tendon debridement, and reattachment. However, the requests for medial epicondylectomy, ulnar nerve decompression of the elbow and radial tunnel release were not certified. The California MTUS guidelines indicate that surgery for radial nerve entrapment requires establishing a firm diagnosis on the basis of clear clinical evidence and positive electrical studies that correlate with clinical findings. In this case, electrical studies documenting radial tunnel syndrome have not been submitted and therefore the request for a radial tunnel release is not supported and the medical necessity of the request has not been substantiated. With regard to the request for cubital tunnel release, the guidelines require 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 with activities limitations and failed conservative care including full compliance in therapy, use of elbow pads, removing opportunities to rest the elbow on the ulnar groove and avoiding nerve irritation at night by preventing prolonged flexion while sleeping. In this case, electrodiagnostic studies documenting cubital tunnel syndrome correlating with clinical findings have not been submitted. As such, the request for a cubital tunnel release is not supported. With regard to the request for medial epicondylectomy, the guidelines necessitate chronic pain over the medial epicondyle and functional limitations which have not been documented. As such, the request for medial epicondylectomy is not supported. In light of the foregoing, the requests for right medial epicondylectomy, ulnar nerve decompression of elbow and radial tunnel release are not supported and the medical necessity of these requests has not been substantiated.