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| Case Number: | CM15-0039394 | | |
| Date Assigned: | 03/09/2015 | Date of Injury: | 07/20/2012 |
| Decision Date: | 05/01/2015 | UR Denial Date: | 02/17/2015 |
| Priority: | Standard | Application Received: | 03/02/2015 |

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: 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:

The injured worker is a 49-year-old male who sustained an industrial injury on 7/20/12. The mechanism of injury was documented as repetitive motion. Past surgical history was positive for right carpal tunnel release in 2012 and left carpal tunnel release in 2013. Past medical history is positive for diabetes, cardiac stents x 3, hypertension, pacemaker, and gastric bypass. Records documented recent conservative treatment specific to lateral epicondylitis, including strapping, injections, anti-inflammatory medications, and therapy. The 12/18/14 orthopedic report indicated that the injured worker had chronic bilateral elbow pain and weakness, equal on both sides. Symptoms occurred with mild activity and were relieved with rest. Over the past several months, he had been experiencing slow but progressive recurrent paresthesias in the median nerve distribution bilaterally. The diagnosis was lateral epicondylitis and authorization was requested for left lateral epicondylar surgery. An EMG was requested to assess his carpal tunnel syndrome. The 1/9/15 electrodiagnostic study noted evidence of mild to moderate carpal tunnel syndrome on the right, mild to moderate cubital tunnel syndrome on the right, and mild cubital tunnel syndrome on the left. There was no underlying peripheral neuropathy. The 2/10/15 treating physician report cited complaints of left lateral elbow pain, and paresthesias along the median nerve distribution on the right and along all anesthetist distributions bilaterally. Left upper extremity exam documented tenderness to palpation and percussion over the lateral epicondyle and insertion of the extensor carpi radialis brevis. There was left lateral epicondyle pain with resisted wrist extension and supination. There were positive wrist compressive tests bilaterally, and positive Phalens and Tinels tests on the right. There were positive compression tests

bilaterally at the cubital canal, positive Tinel's at the cubital canal bilaterally, and positive elbow hyperflexion tests bilaterally. The diagnosis was recurrent right carpal tunnel syndrome following carpal tunnel release, bilateral cubital tunnel syndrome, and left lateral epicondylitis. Right cubital tunnel syndrome was currently worsening compared to 2012 testing, symptomatic and without treatment. The treatment plan recommended right cubital tunnel release with ulnar nerve subfascial transposition. The patient was deemed a surgical candidate for left lateral epicondylitis. The 2/17/15 utilization review non-certified the request for right open cubital tunnel release with ulnar nerve transposition, right forearm myofascial flap for ulnar nerve subluxation, long arm splint right upper extremity placed on intraoperative, Keflex 500 mg #12, and Norco 10/325 mg #40. The rationale indicated that MTUS guidelines recommend against submuscular transposition, and state there is insufficient evidence for anterior transposition, and there was no compelling reason to support the medical necessity of ulnar nerve transposition.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right open cubital tunnel release with ulnar nerve transposition: 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): 36 and 37.

Decision rationale: The California MTUS guidelines state that surgery for ulnar nerve entrapment requires 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, as reflected in significant activity limitations due to the nerve entrapment and that the patient has failed conservative care, including full compliance in therapy, use of elbow pads, removing opportunities to rest the elbow on the ulnar groove, workstation changes (if applicable), and avoiding nerve irritation at night by preventing prolonged elbow flexion while sleeping. Absent findings of severe neuropathy such as muscle wasting, at least 3-6 months of conservative care should precede a decision to operate. Anterior transposition may be supported at the time of attempted decompression if indications are present, but evidence is reported insufficient. Guideline criteria have not been met. This patient presented with a complaint of bilateral elbow pain, and was diagnosed with lateral epicondylitis. An electrodiagnostic study was performed due to symptoms of recurrent carpal tunnel syndrome and found evidence of mild to moderate right cubital tunnel syndrome. There were paresthesias noted in all anesthetic distributions. There were positive compression, Tinel's and elbow hyperflexion tests bilaterally at the cubital canal. Detailed evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial for right cubital tunnel syndrome and failure has not been submitted. Therefore, this request is not medically necessary at this time.

Right forearm myofascial flap for ulnar nerve subluxation after transposition: 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): 36 and 37.

Decision rationale: The California MTUS guidelines state that surgery for ulnar nerve entrapment requires establishing a firm diagnosis on the basis of clear clinical evidence and positive electrical studies that correlate with clinical findings. Absent findings of severe neuropathy such as muscle wasting, at least 3-6 months of conservative care should precede a decision to operate. Guidelines state that there are quality studies available on submuscular transposition, and that submuscular transposition has not been shown to be beneficial. This surgical option is recommended against. Guideline criteria have not been met. This patient presented with a complaint of bilateral elbow pain, and was diagnosed with lateral epicondylitis. An electrodiagnostic study was performed due to symptoms of recurrent carpal tunnel syndrome and found evidence of mild to moderate right cubital tunnel syndrome. There were paresthesias noted in all anesthetic distributions. There were positive compression, Tinels and elbow hyperflexion tests bilaterally at the cubital canal. Detailed evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial for right cubital tunnel syndrome and failure has not been submitted. There is no rationale presented to support the medical necessity of this request in the absence of guideline support. Therefore, this request is not medically necessary.

Long arm splint right upper extremity placed on intraoperatively: Upheld

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): 41 and 42.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Kelfex 500mg #12: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Bratzler DW, Dellinger EP, Olsen KM, Perl TM, Auwaerter PG, Bolon MK, Fish DN, Napolitano LM, Sawyer RG, Slain D, Steinberg JP, Weinstein RA. Clinical practice guidelines for antimicrobial prophylaxis in surgery. Am J Health Syst Pharm. 2013 Feb 1;70(3):195-283.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Norco 10/325mg #40: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Hydrocodone/Acetaminophen Page(s): 76-80 and 91.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.