

<b>Case Number:</b>	CM14-0123677		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	09/04/2008
<b>Decision Date:</b>	10/29/2014	<b>UR Denial Date:</b>	07/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/05/2014

### 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 and is licensed to practice in Texas. 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 44-year-old female who reported an injury on 09/04/2008. The mechanism of injury was noted to be a lifting injury. Her diagnoses were noted to include chronic right lateral epicondylitis with forearm myofasciitis, right carpal tunnel syndrome, volar wrist ganglion cyst resection, and posterior interosseous nerve entrapment. Her previous treatments were noted to include physical therapy, cortisone injections, and NSAIDs. The provider indicated an MRI to the right wrist, performed 08/08/2013, revealed ulnar positive variance without definite tear through the radial portion of the TFCC and/or a definite tear of the lunotriquetral interosseous ligament. An occult area of mucinous/myxoid deterioration and/or very fine tearing in an accentuated or narrowed portion of the more radial portion of the triangular fibrocartilage may be present. Extensor carpi ulnaris tendinosis with potential occult split tear adjacent to the area of the ulnar styloid process. Multi locational within the extensor tendon sheath involved the first through fifth extensor tendon compartments, the greatest involved the second extensor tendon compartment. The provider indicated an electromyography/nerve conduction study, performed 01/07/2014, revealed mild right carpal tunnel syndrome, mild right radial nerve entrapment neuropathy/radial tunnel syndrome at the elbow, mostly likely at the level of arcade of Frohse. There was no evidence of ulnar nerve entrapment or acute cervical radiculopathy in the right upper extremity. The progress note dated 02/05/2014 revealed complaints of discomfort over the dorsal radial forearm with pain that radiated into the wrist and pain with long finger extension. The physical examination revealed a strength of 20/25/20 on the right and 40/42/40 on the left. The injured worker had full range of motion to the elbow, wrist, and fingers. The physical examination revealed pain directly on course of the posterior interosseous nerve and pain with the resisted long finger extension. The examination revealed normal discrimination and mildly positive Tinel's at the wrist over the

median nerve. The provider indicated for the injured worker to receive a cortisone injection along the course of the posterior interosseous nerve and if there was no long lasting improvement, the injured worker may have require formal decompression of the posterior interosseous nerve. The progress note dated 06/27/2014 revealed complaints of pain to the right elbow, forearm, and arm that occasionally radiated up to the shoulder area. The injured worker reported the injection did not provide any relief, and that she continued with numbness/tingling to the right hand. The injured worker indicated her pain was rated 3/10 to 7/10. The provider indicated the physical examination revealed no change in the range of motions to the elbows and there was continued tenderness over the posterior interosseous nerve with positive Tinel's at the wrist. There was myofascial tenderness of proximal extensor forearm muscles and mild positive lateral elbow pain with resisted wrist extension. The progress note dated 07/03/2014 revealed the injured worker complained of cramping pain over the dorsum of her forearm. The physical examination revealed pain over the dorsal forearm and a resisted long finger extension and resisted dorsiflexion. There was full range of motion to the elbow and wrist. The progress note dated 07/23/2014 revealed the injured worker complained of pain along the course of the posterior interosseous nerve with tenderness with resistive extension of her wrist, thumb, and longer finger. The physical examination revealed pain directly over the dorsal forearm and weakness with dorsiflexion and longer finger extension. There was full range of motion to the elbow and wrist. The Request for Authorization form was not submitted within the medical records. The request was for 1 right forearm decompression of the posterior interosseous nerve, due to pain, and postoperative physical therapy visits for the right forearm; however, the provider's rationale was not submitted within the medical records.

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

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

**Twelve post operative physical therapy visits for the right forearm:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 21.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**One right forearm decompression of the posterior interosseous nerve:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 44-45.

**Decision rationale:** The request for one right forearm decompression of the posterior interosseous nerve is not medically necessary. The injured worker complains of pain over the

dorsal forearm and weakness with dorsiflexion and long finger extension. The California MTUS/ACOEM Guidelines state a study evaluated 28 elbows (26 patients with the average duration of symptoms of 23 months); half were treated with a decompression of the posterior interosseous nerve surgery and half with the lengthening of the distal tendon of the extensor carpi radialis brevis surgery. The authors found that overall outcome after a mean followup of 31 months after the primary operation was successful in 60% of the cases. They concluded that the present results seemed to indicate that the PIN neurolysis and lengthening of the tendon of the ECRB muscle are of similar value in the surgical treatment of resistant tennis elbow. Neither of these methods, however, can be considered a very effective treatment in chronic tennis elbow. The last study evaluated 23 elbows (duration of patient symptoms not indicated) and treated them with open release surgery with drilling or without drilling. The authors concluded that drilling confers no benefit and actually causes more pain, stiffness, and wound bleeding than not drilling. Quality studies are available in surgery for patients with chronic symptoms of lateral epicondylalgia, although they use different surgical techniques and did not include an observation group. Benefits of less invasive procedures are suggested. This option is high cost, invasive, and has moderate side effects. Thus, surgery for lateral epicondylalgia should be a consideration for those patients who fail to improve after a minimum of 6 months of care that includes at least 2 to 4 different types of conservative treatment. However, there are unusual circumstances in which, after 3 months of failed conservative treatment, surgery may be considered. The progress note dated 07/23/2014 revealed the injured worker complained of pain along the course of the posterior interosseous nerve with tenderness with resistive extension of her wrist, thumb, and longer finger. The physical examination revealed pain directly over the dorsal forearm and weakness with dorsiflexion and longer finger extension. There was full range of motion to the elbow and wrist. The injured worker has failed conservative measures of treatment, which included physical therapy, cortisone injections, and NSAIDs. The injured worker had relief with injection of the posterior interosseous nerve; however, there is no objective documentation provided which quantified the injured worker's pain relief and improved function with the injection. In addition, a note from another provider stated the injection provided no relief. Therefore, the request is not medically necessary.