

Case Number:	CM14-0215864		
Date Assigned:	01/05/2015	Date of Injury:	12/05/2012
Decision Date:	03/03/2015	UR Denial Date:	11/24/2014
Priority:	Standard	Application Received:	12/23/2014

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. 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:

The injured worker is a 51-year-old male who complains of right elbow pain. The date of injury is 12/5/2012. He was unloading heavy machinery off a truck when he felt a pop in his elbow. He had pain in the lateral and medial aspect of the elbow with catching and locking sensations. Per consultation, report dated 10/22/2014 the pain level was relatively high with maximum pain of 8/10 and associated catching and popping in his arm. He was taking Celebrex and other medications as needed. He did 8 months of physical therapy for the lateral epicondylitis with no relief. He underwent surgery on the right elbow in August 2013 consisting of debridement of the lateral epicondyle and osteotomy but it did not help the pain. There is a past history of rheumatoid arthritis documented in the medical records. There is also a history of gout. On examination, the right elbow range of motion was from 0-140. He had pain at the extremes of flexion and extension. He was nontender to palpation medially and laterally. There was a healed scar of the lateral incision over the lateral epicondyle. X-rays revealed some degenerative changes in the elbow and an 8 mm loose body in the coronoid fossa, which was unchanged from previous imaging studies including 2 MRI scans in 2013. This may represent an osteophyte or a loose body. Documentation indicates electrodiagnostic studies of the right upper extremity performed on 9/21/2014 were negative for peripheral nerve entrapment or radiculopathy. Per AME of July 28 2014 MRI, scans of the right elbow were performed on January 2, 2013 and June 19, 2013. The first MRI showed a small elbow joint effusion, 7 mm intra-articular loose body noted in the coronoid fossa, high-grade partial thickness tear of the common extensor origin, and tear of the radial collateral ligament. The second MRI scan of June 19, 2013 when

compared to the prior study showed a partial thickness tear of the common extensor origin as described consistent with lateral epicondylitis, without any full thickness defect. There was a proximal tear of the radial collateral ligament with a focal full-thickness component. There was minimal biceps insertional tendinosis. Degenerative changes were noted with a joint effusion and a 7 mm loose body along the coronoid fossa. The diagnosis based upon the agreed medical evaluation was right shoulder impingement syndrome, right elbow lateral epicondylar release with osteotomy (August 14, 2013), and bilateral elbow cubital tunnel syndrome and right wrist probable carpal tunnel syndrome based upon the clinical examination. A subsequent EMG and nerve conduction study was negative and the agreed medical examiner modified his report accordingly. The report does not document need for any additional treatment for the right elbow. The examiner did recommend a subacromial cortisone injection, exercise program and night splints for the right wrist. The disputed issue at this time pertains to a request for additional surgery for the right elbow including arthroscopy, synovectomy and loose body removal. The imaging studies have not revealed any change in the position of the 7 mm osteophyte or loose body in the coronoid fossa. This would indicate that it is not mobile. This was not approached at the time of the surgery on the lateral epicondyle. The available documentation indicates one injection into the lateral epicondyle in the past but no intra-articular corticosteroid injection into the elbow is documented despite the reported degenerative changes in the elbow. The request for arthroscopy of the right elbow with removal of the loose body and synovectomy was noncertified by utilization review as Radiology reports of the imaging studies including x-rays and MRI scans were not provided and the operative report of the prior elbow surgery was also not provided. This is now appealed to an independent medical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic loose body removal synovectomy, right elbow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Center for Biotechnology Information (<http://www.ncbi.nlm.nih.gov/pubmed/7566913>); Orthop Clin North Am. 1995 Oct; 26(4): 679-89 Arthroscopic removal of loose bodies of the elbow. Greis PE1, Halbrecht J, Plancher KD

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

Decision rationale: California MTUS guidelines indicate surgical considerations for significant limitations of activity for more than 3 months, failure to improve with exercise programs to increase range of motion and strength of the musculature around the elbow, or clear clinical and electrophysiologic or imaging evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair. The imaging studies have revealed evidence of degenerative changes in the elbow. There is a 7 mm bony osteophyte or loose body in the coronoid fossa that has remained unchanged over the years. This was noted on the x-rays and also on the MRIs in the year 2013 and is still present. The available documentation does not indicate this to be the pain source. There is no tenderness over this area documented. The location has not changed. The crepitus in the joint with range of motion is due to the

degenerative changes seen on the x-rays. Arthroscopy of the elbow is not likely to be of benefit in the presence of degenerative changes in the joint. As such, the requested surgical procedure is not supported by guidelines, and the medical necessity is not established.