

<b>Case Number:</b>	CM15-0110345		
<b>Date Assigned:</b>	06/17/2015	<b>Date of Injury:</b>	05/21/2004
<b>Decision Date:</b>	07/20/2015	<b>UR Denial Date:</b>	05/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2015

### 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 59 year old female sustained an industrial injury on 5/21/04. She subsequently reported shoulder and elbow pain. Diagnoses include sprain of neck, shoulder, elbow, and chronic pain syndrome. Treatments to date include x-ray and nerve conduction testing, injections, elbow surgery, physical therapy and prescription pain medications. The injured worker continues to experience left elbow pain. Upon examination, there was pain in the elbow with resisted wrist extension and flexion with tenderness. There was some subluxation with elbow flexion and hyperflexion causing numbness and tingling into the fingers. Range of motion was reduced. Tinel's testing was positive. The provider requested arthroscopy with debridement, removal of loose bodies, and possible ligamentous reconstruction of the left elbow. Surgery has been certified. The disputed request pertains to post-operative Occupational Therapy 2x4 for the left elbow that was modified to 6 visits.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-operative Occupational Therapy 2x4 for the left elbow:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 16.

**Decision rationale:** An agreed medical reexamination of February 16, 2015 is noted. The date of injury was reported to be May 21, 2004. The injured worker stated that her worst pain was in the left elbow. It was more on the lateral aspect. She also reported pain in the left shoulder and right wrist and forearm including the index finger and thumb. In addition, she reported diffuse right shoulder pain. The orthopedic progress report dated May 11, 2015 indicates continuing pain in the left shoulder and elbow. Examination of the elbow revealed a scar on the posteromedial aspect representing the prior surgical procedure. The ulnar nerve could be palpated posterior to the medial epicondyle with some subluxation with elbow flexion. There was a positive Tinel sign over the ulnar nerve at the cubital tunnel. There was pain to palpation over the medial and lateral epicondyles. There was no instability noted. MRI of the left elbow was unofficially reported to show a tear of the lateral collateral and ulnar collateral ligaments with slight posterior subluxation over the radial head, probable intra-articular body in the radiocapitellar compartment, and moderate joint effusion. X-rays of the left elbow dated 4/20/2015 were reported to show a minimally displaced fracture of the radial head and spurring of the coronoid process. There was mild narrowing of the radiocapitellar joint space. The diagnosis was left elbow pain, medial and lateral epicondylitis with associated tear of lateral collateral and ulnar collateral ligaments and probable intra-articular loose bodies in the radiocapitellar compartment per MRI scan of 3/18/2015, left cubital tunnel syndrome, mild carpal tunnel syndrome, history of carpal tunnel release in 2005, partial-thickness bursal surface tear, left supraspinatus in the setting of chronic shoulder pain with associated mild component of adhesive capsulitis improving but still symptomatic, and history of left elbow arthroscopic debridement of flexor pronator origin, synovectomy, and excision of loose body performed by [REDACTED] on 10/6/2009. The plan was surgical management with arthroscopic examination, debridement, and removal of loose bodies from the elbow joint, possible reconstruction of the lateral ulnar collateral ligament with a semitendinosus allograft and decompression of the ulnar nerve at the left elbow. The disputed request pertains to postoperative occupational therapy 2 x 4 to the left elbow. The request was modified to 6 visits by utilization review on 5/19/2015. California MTUS postsurgical treatment guidelines indicate 20 visits over 2 months for elbow diagnostic arthroscopy and arthroscopic debridement. The initial course of therapy is one half of these visits which is 10. The request as stated is for 8 visits which is within the guideline recommendation. As such, the medical necessity of the requested 8 visits is medically necessary.