

Case Number:	CM15-0070662		
Date Assigned:	04/20/2015	Date of Injury:	03/02/2014
Decision Date:	06/17/2015	UR Denial Date:	03/17/2015
Priority:	Standard	Application Received:	04/14/2015

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:

The injured worker is a 40-year-old female, who sustained an industrial/work injury on 3/2/14. She reported initial complaints of wrist and elbow pain. The injured worker was diagnosed as having epicondylitis and remote possibility of left carpal tunnel syndrome. Treatment to date has included medication, physical therapy, and diagnostics. Electromyography and nerve conduction velocity test (EMG/NCV) was performed. Per the primary treating physician's progress report of 12/23/14, there was notation of the injection decreasing the pain with some discomfort but much less than prior to the treatment. Grip strengths were 28/28/30 on the right and 26/22/26 on the left. Per the primary physician's progress report (PR-2) on 3/3/15, the requested treatments include cutaneous nerve left forearm and extensor muscle slide procedure, neurectomy of posterior branch lateral.

IMR ISSUES, DECISIONS AND RATIONALES

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

Extensor Muscle Slide Procedure, Neurectomy of Posterior Branch of Lateral Cutaneous Nerve of the Forearm under local anesthesia, as an outpatient with Intravenous Sedation:
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): 35-36. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section: Elbow, Topic: Surgery for epicondylitis; Journal of Hand Surgery Am. 2013 Feb; 38(2) 344-9 Denervation of the lateral humeral epicondyles for treatment of chronic lateral epicondylitis.

Decision rationale: The injured worker is a 40-year-old right-hand-dominant female with complaints of left upper extremity, left elbow, left forearm, and left hand pain and paresthesias related to an industrial trauma of March 2, 2014. She experiences paresthesias from the medial aspect of her left elbow into the forearm and left fourth and fifth digits. She also complains of lateral elbow pain and forearm pain. There is a history of hypothyroidism and hypercholesterolemia for which she is on medication. Electrodiagnostic studies were obtained on December 4, 2014. There was no evidence of cubital tunnel syndrome, carpal tunnel syndrome, radial tunnel syndrome, or cervical radiculopathy. Epicondylectomy versus denervation of the lateral humeral epicondyle for lateral humeral epicondylitis has been published in the literature. The diversity of surgical approaches for lateral humeral epicondylitis suggests perhaps that the ideal technique has not been determined. In this study, a diagnostic nerve block of the posterior branches of the posterior cutaneous nerve of the forearm proximal to the lateral humeral epicondyle was carried out. Denervation of the lateral epicondyle was effective in relieving pain in 80% of patients with chronic lateral epicondylitis who had a positive response to the local anesthetic block of the posterior branches of the posterior cutaneous nerve of the forearm. In this case, the documentation provided does not indicate that the nerve block has been performed. As such, the request for this surgery without the diagnostic nerve block is not supported. Furthermore, the lateral cutaneous nerve of the forearm does not innervate the lateral epicondyle according to the available literature. As such, the request for neurectomy of the lateral cutaneous nerve of the forearm is not supported. California MTUS guidelines indicate surgical considerations for lateral epicondylalgia should only be for those patients who fail to improve after 6 months of care that includes at least 3-4 different types of conservative treatment. ODG guidelines require one year of conservative treatment. The documentation provided indicates that the injured worker received 2 corticosteroid injections and attended 12 sessions of physical therapy. Details of the physical therapy and the modalities used were not submitted. It is not known if the conservative treatment was provided continuously for 6 months or not. Without knowing the details of the conservative treatment and if 6 months of therapy and 3-4 types of conservative treatment were utilized, the medical necessity of the requested procedures cannot be determined. The second request pertains to the surgical procedure of extensor muscle slide for lateral epicondylalgia. The same guideline criteria apply to this surgery as well. The provider is requesting two separate surgical procedures at the same time for the same condition. For reasons mentioned above, particularly the incomplete evidence of conservative care as required by guidelines, the requested procedure is not medically necessary.