

Case Number:	CM15-0092619		
Date Assigned:	05/19/2015	Date of Injury:	10/22/2013
Decision Date:	06/18/2015	UR Denial Date:	04/22/2015
Priority:	Standard	Application Received:	05/13/2015

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 56-year-old male who sustained an industrial injury on 10/22/13. Injury occurred when he was walking on a sandy surface and stepped on a buried PVC pipe. He twisted his right ankle and fell. Past surgical history was positive for remote lumbar hemilaminectomy and discectomy. Records documented left elbow MRI evidence of moderate tendinosis with partial thickness disruption of the common extensor origin, and radial collateral and lateral ulnar collateral ligament degenerative changes without full thickness tears. Prior treatment had included injections, physical therapy, acupuncture, and bracing. The 4/2/15 treating physician report indicated that the injured worker presented with left elbow pain. A cortisone injection had been provided at the lateral epicondyle with continued pain and pain more proximally. Left elbow exam documented appropriate range of motion, residual lateral epicondylar tenderness, pain over the radial tunnel, and pain with resisted wrist extension. The impression documented constant left lateral elbow pain with lateral epicondylitis and a change in the character of symptoms concerning for radial tunnel syndrome. An injection was provided at the radial tunnel without benefit and radial tunnel syndrome was ruled-out. Authorization was requested for arthroscopic evaluation of the left elbow with open versus arthroscopic lateral epicondylar release. The 4/22/15 utilization review non-certified the request for left elbow arthroscopy debridement with possible repair of ligament, open versus arthroscopic lateral epicondylar release and associated post-op physical therapy as there was no evidence that recent comprehensive conservative treatment had been tried and had failed. The 5/1/15 treating physician appeal letter indicated that the injured worker had signs and symptoms consistent with

lateral epicondylitis. His symptoms had been on going for over a year. Conservative treatment had included multiple cortisone injections, counterforce bracing, wrist bracing, anti-inflammatory medications, therapeutic exercise, and activity modification. There was MRI evidence of lateral epicondylitis consistent with clinical exam findings of pain with resisted wrist and long finger extension, and tenderness to palpation over lateral epicondylar insertion. The diagnosis included recalcitrant lateral epicondylitis. Appeal of the left elbow surgery was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

One left elbow arthroscopy debridement with possible repair of ligament, open versus arthroscopic lateral epicondylar release: Overturned

Claims Administrator 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, Elbow (Acute & Chronic), Surgery for Epicondylitis.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 35-36.

Decision rationale: The California MTUS updated ACOEM elbow guidelines state that surgery for lateral epicondylalgia should only be a consideration for those patients who fail to improve after a minimum of 6 months of care that includes at least 3-4 different types of conservative treatment. However, there are unusual circumstances in which, after 3 months of failed conservative treatment, surgery may be considered. Although some individuals will improve with surgery for lateral epicondylalgia, at this time there are no published RCTs that indicate that surgery improves the condition over non-surgical options. Guideline criteria have been met. This injured worker presents with chronic left elbow pain. Clinical exam findings and imaging evidence are consistent with lateral epicondylitis. Detailed evidence of at least 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

12 post surgery physical therapy sessions: Overturned

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 17.

Decision rationale: The California Post-Surgical Treatment Guidelines for lateral epicondylitis suggest a general course of 12 post-operative visits over 12 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 6 visits. If it is determined additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. This is the initial

request for post-operative physical therapy and, although it exceeds recommendations for initial care, is within the recommended general course. Therefore, this request is medically necessary.