

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

Dated: 11/6/2013

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/23/2013
Date of Injury:	6/23/2010
IMR Application Received:	8/6/2013
MAXIMUS Case Number:	CM13-0007887

- 1) MAXIMUS Federal Services, Inc. has determined the request for **surgery: right lateral epicondyle reconstruction with neurolysis of the radial nerve/interferential unit and cold therapy.** is not medically necessary and appropriate.

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/6/2013 disputing the Utilization Review Denial dated 7/23/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/6/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **surgery: right lateral epicondyle reconstruction with neurolysis of the radial nerve/interferential unit and cold therapy. is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

The patient is a 42-year-old female who reported a work-related injury to her right upper extremity on 06/23/2010, specific mechanism of injury not stated. Electrodiagnostic studies of the bilateral upper extremities dated 02/07/2013, signed by Dr. [REDACTED], revealed no abnormalities. The document evidenced no carpal tunnel syndrome and no ulnar nerve entrapment or cervical radiculopathy. The clinical note dated 06/25/2013 reported that the patient was seen under the care of Dr. [REDACTED] for her pain complaints. The provider documented that the patient reported a right elbow injection gave her pain relief for about 1 week over the lateral epicondylar region. However, the paresthesias down her forearm did not persist, but she remained tender along the course of the radial nerve. Physical examination noted that equal grip strength was noted to be slightly diminished to the right. The provider documented that the patient was a surgical candidate for a right lateral epicondyle reconstruction with neurolysis of the radial nerve.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for surgery: right lateral epicondyle reconstruction with neurolysis of the radial nerve/ interfemoral unit and cold therapy.:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) The Expert Reviewer based his/her decision on American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) American College of Occupational and Environmental Medicine, Chapter 10, page 239-240, Online Edition, which is part of MTUS.

Rationale for the Decision:

MTUS/ACOEM indicates, "Conditions that produce objective evidence of nerve entrapment and that do not respond to nonsurgical treatment can be considered for surgery when treatment failure has been documented." The employee presents with electrodiagnostic studies which revealed no abnormalities to the bilateral upper extremities. **The request for surgery: right lateral epicondyle reconstruction with neurolysis of the radial nerve/ interfemoral unit and cold therapy. is not medically necessary or appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/sm

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.