

<b>Case Number:</b>	CM13-0017964		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	12/10/2012
<b>Decision Date:</b>	08/04/2015	<b>UR Denial Date:</b>	07/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/08/2013

### 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:

This injured worker is a 39-year-old male who sustained an industrial injury on 12/10/12. Injury occurred when he was pulling and felt a sudden pop on the lateral aspect of his elbow. The 4/25/13 initial hand surgery consult cited complaints of persistent left lateral elbow and forearm pain radiating towards the back of the wrist with intermittent numbness and tingling in both the median and ulnar nerve distributions that wake him at night. Conservative treatment had included tennis elbow band, wrist splint, anti-inflammatory medications, therapy, and 2 corticosteroid injection into the lateral epicondyle. He had tenderness over the left lateral epicondyle and radial tunnel with pain with resisted wrist extension, middle finger extension, and forearm supination. He had positive Tinel's, Phalen's, and compression test at the palm with positive Tinel's, flexed elbow compression test, and tenderness at the left cubital tunnel. He had no first dorsal interossei or thumb abductor atrophy. X-rays showed no bony or ligamentous abnormalities. Wrist imaging revealed partial thickness tear of the lunotriquetral ligament with extensor carpi ulnaris tendonitis. He was diagnosed with left lateral epicondylitis, radial tunnel syndrome, cubital tunnel syndrome, and carpal tunnel syndrome. The treatment plan recommended electrodiagnostic to evaluate the severity of the carpal tunnel and cubital tunnel syndrome. Continued conservative treatment was recommended. He was to continue with current work modifications. The 7/2/13 treating physician report cited significant lateral left elbow pain, with paresthesias. The injured worker reported that the pain bothered him more than the paresthesias. Physical exam documented the area of maximum tenderness was over the lateral epicondyle and radial tunnel, and was otherwise unchanged from 4/25/13. Electrodiagnostic

studies confirmed mild cubital tunnel syndrome on the left. The injured worker had an acute injury with imaging evidence of tearing of the common extensor origin. He had failed conservative treatment with rest, ice, anti-inflammatory, prolonged splinting, therapy, activity modification, and corticosteroid injections. Authorization was requested for left lateral epicondyle debridement and concomitant radial tunnel release through the same incision, and a comprehensive history and physical. The 7/18/13 utilization review non-certified the request for left radial tunnel repair and the comprehensive history and physical. The rationale for this non-certification was not provided.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Left Radial Tunnel Release: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2nd Edition (2008), Elbow Disorders, pages 603-606.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 38.

**Decision rationale:** The California MTUS guidelines state that surgery for radial nerve entrapment requires establishing a firm diagnosis on the basis of clear clinical evidence. If the patient fails at least 3 to 6 months of conservative treatment, surgery may be a reasonable option if there is unequivocal evidence of radial tunnel syndrome including positive electrodiagnostic studies and objective evidence of loss of function. Guideline criteria have not been met. This patient presents with left elbow pain and paresthesias in the median and ulnar nerve distributions. Clinical exam findings are suggestive of carpal tunnel and cubital tunnel syndrome. There is pain over the radial tunnel and with resisted middle finger extension and supination. However, there is no positive electrodiagnostic evidence of radial nerve entrapment. Therefore, this request is not medically necessary.

#### **Comprehensive History and Physical: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://guidelines.gov/contnet.aspx?id=242268&search=pre-op+clearance>.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, California Official Medical Fee Schedule, 1999 edition, pages 92-93.

**Decision rationale:** The California Official Medical Fee Schedule states that, under most circumstances, including ordinary referrals, the immediate preoperative visit in the hospital or elsewhere necessary to examine the patient, complete the hospital records, and initiate the treatment program is included in the listed value for the surgical procedure. There is no compelling reason to support the medical necessity of a separate certification for the history and physical which is part of the pre-operative process. Therefore, this request is not medically necessary.