

<b>Case Number:</b>	CM13-0015270		
<b>Date Assigned:</b>	10/07/2013	<b>Date of Injury:</b>	07/12/2007
<b>Decision Date:</b>	01/13/2014	<b>UR Denial Date:</b>	08/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/22/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and Hand 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 63-year-old female with a reported date of injury on 07/12/2007. The patient had a positive Tinel's to the cubital tunnel, positive flexion test, and a contracture of her left small and ring fingers with pain, numbness, and tingling. She was unable to straighten her fingers and she was developing a claw hand on the left. The patient's left elbow appearance was normal, it was negative for tenderness over the medial epicondyle, negative for tenderness over the lateral epicondyle, negative for pain with resisted wrist flexion, negative for pain with resisted long finger extension, and motor testing was 5/5 to all muscle groups. The diagnoses included claw hand, left, bilateral cubital tunnel syndrome, right knee degenerative joint disease, meniscal and popliteal cysts. It also included, right shoulder tendinitis, herniated disc, degenerative disc disease lumbar spine, radiculitis left lower extremity, cervical, thoracic multilevel disc protrusions, right trigger thumb, chronic regional pain syndrome type 1, status post right carpal tunnel release and left knee meniscal tear. The provider's treatment plan consisted of a request for a left cubital tunnel release.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Cubital Tunnel Release:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 240.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 45.

**Decision rationale:** The California MTUS guidelines do not specifically address cubital tunnel release. ACOEM states, surgery for ulnar nerve entrapment requires establishing a firm diagnosis on the basis of clear clinical evidence and positive electrical studies that correlate with clinical findings. A decision to operate requires significant loss of function, as reflected in significant activity limitations due to the nerve entrapment and that the patient has failed conservative care, including full compliance in therapy, use of elbow pads, removing opportunities to rest the elbow on the ulnar groove, workstation changes (if applicable), and avoiding nerve irritation at night by preventing prolonged elbow flexion while sleeping. Before proceeding with surgery, patients must be apprised of all possible complications, including wound infections, anesthetic complications, nerve damage, and the high possibility that surgery will not relieve symptoms. Absent findings of severe neuropathy such as muscle wasting, at least 3-6 months of conservative care should precede a decision to operate. Within the provided documentation, the requesting physician did not include adequate documentation that the patient had undergone an adequate course of conservative care for the left elbow including full compliance in therapy, use of elbow pads, removing opportunities to rest the elbow on the ulnar groove, work station changes (if applicable), and avoiding nerve irritation at night by preventing prolonged elbow flexion while sleeping. Additionally, within the provided documentation the requesting physician did not include electrodiagnostic studies indicating the patient had a diagnosis of cubital tunnel syndrome. The electrodiagnostic study report dated 06/26/2013 did not indicate a diagnosis of cubital tunnel in the left upper extremity. Therefore, the request for a cubital tunnel release is neither medically necessary nor appropriate.