

Case Number:	CM13-0021898		
Date Assigned:	06/06/2014	Date of Injury:	02/09/2012
Decision Date:	11/25/2014	UR Denial Date:	08/23/2013
Priority:	Standard	Application Received:	09/09/2013

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. The expert reviewer is Board Certified in Orthopedic Surgeon and is licensed to practice in Texas. 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/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 injured worker is a 55-year-old female who reported an injury on 02/09/2012. The mechanism of injury was not submitted for this review. The injured worker's treatment history included occupational therapy visits, on 05/21/2013, status post right wrist flexor tenosynovitis and right carpal tunnel release and x-rays, EMG/NCV studies of right left hand, EMG/NCV study done on 09/21/2011 and labs. The injured worker had undergone an EMG/NCV study of the right and left hand that revealed there was electro diagnostic evidence of severe right carpal tunnel syndrome (median nerve entrapment at wrist) effecting sensory motor components. There was electro diagnostic evidence of mild Left Carpal Tunnel Syndrome (median nerve entrapment at wrist) effecting sensory components. Most recent progress report, dated 07/31/2013, the injured worker was evaluated and it was documented the injured worker complained of persistent left sided symptoms. Physical examination revealed positive Tinel's and flexion compression test at the left elbow. The nerve was stable within the groove. The injured worker had positive Tinel's, Durkan's, and Phalen's signs on the left side. There were hypoesthesia to light touch in the left median nerve distribution and hyperesthesia to pinwheel testing in the left index finger. The injured worker had hypoesthesia to a pinwheel testing to the left middle finger. There was hypoesthesia to the pinwheel testing in the ulnar nerve distribution on the left. Intrinsic strength was 5/5. The treatment plan included cubital and carpal tunnel release. The injured worker had persistent and consistent findings with cubital and carpal tunnel on the left. Diagnosis included bilateral cubital tunnel and carpal tunnel syndromes, resolving right ring and middle finger flexor tenosynovitis. The Request for Authorization was not submitted for this review.

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: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS: ACOEM, Occupational Medicine Practices Guidelines, Elbow Disorders; Surgical Considerations

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Surgical Considerations- Elbow Disorders. Ulnar Nerve Entrapment Page(s): 45.

Decision rationale: The request for Left Cubital Tunnel Release 64718 is not medically necessary. CAMTUS/ACEOM states that ulnar nerve entrapment Five studies were reviewed for ulnar nerve decompression surgery All of intermediate quality. All the studies compared surgical techniques. None incorporated a group receiving physical therapy or non-intervention as a control. In addition, none of the studies distinguished between the different types of ulnar neuropathies at the elbow. Evidence is lacking that any of these surgeries has advantages over conservative treatment. The simple ulnar nerve release does have some evidence of benefits over more complicated surgical procedures such as transposition. Surgery for ulnar nerve entrapment requires establishing a firm diagnosis based on 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 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. The injured worker has the appropriate signs and symptoms of left cubital tunnel syndrome on H and P, but there has been no confirmation of ulnar nerve compression on NCT that was done. Unfortunately, with the lack of evidence of ulnar nerve compression on NCT, a left cubital tunnel release is not medically necessary. As such, the request for Left Cubital Tunnel Release 64718 is not medically necessary.