

Case Number:	CM13-0033015		
Date Assigned:	12/06/2013	Date of Injury:	03/25/2013
Decision Date:	07/23/2014	UR Denial Date:	09/13/2013
Priority:	Standard	Application Received:	10/09/2013

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 General 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 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:

This 37 year old male claims a date of injury of 3/25/13. The mechanism of injury was repetitive movements with keyboarding. He complained of constant numbness at the elbow with swelling and a painful range of motion at the elbow. A positive resistant tennis elbow test, cubital tunnel compression test is also reported as positive. There is documented decreased sensation in an ulnar nerve distribution. Electrodiagnostic studies 5/7/13 was within normal limits. There had been activity modification, medications prescribed, a tennis elbow strap and a wrist support provided, and lateral epicondyle steroid injection given. The injection reportedly did provide relief for a couple of weeks. Records document completion of 5 physical therapy sessions. The request was for right cubital tunnel decompression and debridement of the lateral epicondyle with 12 post-operative physical therapy sessions. Apparently that procedure was done 11/14/13 with carpal tunnel release and lateral epicondylar debridement with reattachment of the extensor mechanism origin.

IMR ISSUES, DECISIONS AND RATIONALES

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

SURGERY FOR THE RIGHT CUBITAL TUNNEL DECOMPRESSION WITH A RIGHT EPICONDYLAR DEBRIDEMENT: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation 1. American College of Occupational and Environmental Medicine (ACOEM) 2004, Occupational Medicine Practice Guidelines, Chapter 10, Revised Edition, pages 604-605, Surgical considerations for Ulnar Nerve.2. Green's Operative Hand Surgery, 6th Edition, Edited by Dr. Wolfe, Hotchkiss, Pederson, and Kozin, Chapter 30, Compressive Neuropathy, Cubital Tunnel Syndrome, Clinical Diagnosis Considerations for Treatment.

Decision rationale: The MTUS/ACOEM Guidelines, Chapter 10, Revised Edition, pages 604 to 605 for ulnar nerve entrapment 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 and significant activity limitations due to the nerve entrapment and that the patient has failed conservative care, including full compliance and 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." These criteria were detailed within the report of the requesting provider the only missing factor was the nerve conduction studies, which were normal. Green's Operative Hand Surgery, 6th Edition, Edited by Dr. Wolfe, Hotchkiss, Pederson, and Kozin, further defines considerations for cubital tunnel conditions. In that it describes cubital tunnel as, "Compression of the ulnar nerve at the cubital tunnel is extremely common and second in incidence only to carpal tunnel syndrome. The diagnosis is a clinical one, because electrodiagnostic testing is frequently negative. Complaints often include paresthesias and numbness in the smaller and the ring fingers with aching in the medial aspect of the elbow and forearm. Tinel's sign is usually positive over the nerve at or proximal to the cubital tunnel, but the test is overly sensitive and usually bilaterally positive. Provocative testing for cubital tunnel syndrome consisting of combined elbow flexion and digital pressure placed over the ulnar nerve proximal to the cubital tunnel has good sensitivity and specificity." In this instance ulnar nerve studies were negative but the clinical examination did support the diagnosis. Therefore, release of the ulnar nerve at the cubital tunnel is medical necessity.

TWELVE (12) POST-OP PHYSICAL THERAPY SESSIONS: Overturned

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: Post-operative cubital tunnel release physical therapy is reasonable and medically necessary. The request is for 12 sessions. Medical Evidence based Guidelines recommend up to 20 sessions. Therefore, the request for 12 sessions is medically necessary.