

<b>Case Number:</b>	CM14-0001991		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	08/30/2011
<b>Decision Date:</b>	06/16/2014	<b>UR Denial Date:</b>	12/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/06/2014

### 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 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:

The patient is a 60-year-old male [REDACTED] reported an industrial injury on 8/30/11. He reported an onset of neck and bilateral elbow pain due bending over a desk, typing with his elbows resting on the desk, and constant neck motion. The 10/5/11 bilateral upper extremity nerve conduction study findings documented mild peripheral neuropathy of the bilateral upper extremities. A third extremity exam was needed to confirm generalized peripheral polyneuropathy versus multiple entrapments at the wrists. Findings were suggestive of chronic C8 radiculopathy on the right. The right upper extremity EMG was reported as a normal study. The left upper extremity needle EMG was refused. The 11/11/11 cervical spine MRI documented mild to moderate multilevel osteoarthritic changes from C2 to C6, with slight neuroforaminal encroachment at C3/4 and C4/5. The patient is status post left ulnar nerve decompression with anterior transposition and neurolysis of the left elbow ulnar nerve on 8/16/13. The 11/27/13 treating physician report cited right elbow stiffness and swelling, increased pain and tingling from the right elbow, and shooting pain to the left 5th finger (improving). Right elbow physical exam findings documented tenderness and swelling over the medial and lateral epicondyles, pain increased on resisted pronation, and positive Tinel's. Elbow range of motion was reduced fairly symmetrically. Upper extremity strength was 4/5 globally. The diagnosis was cervicgia, cervical radiculopathy, and bilateral ulnar nerve impingement. The treatment plan requested reconsideration of the request for right elbow ulnar nerve transposition with surgical assistant and post-operative physical therapy. The 12/9/13 utilization review denied the request for right ulnar nerve transposition as the electrodiagnostic studies did not establish a firm diagnosis of ulnar neuropathy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RIGHT ELBOW ULNAR NERVE TRANSPOSITION:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 36-37.

**Decision rationale:** The California MTUS guidelines state that 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. Absent findings of severe neuropathy such as muscle wasting, at least 3-6 months of conservative care should precede a decision to operate. In this case, the guideline criteria have not been met. The medical records submitted indicate that the right upper extremity electrodiagnostic studies did not provide positive evidence of ulnar neuropathy. Furthermore, there is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment of the right elbow had been tried and failed. Therefore, the request for right elbow ulnar nerve transposition is not medically necessary and appropriate.

**ASSISTANT SURGEON:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**POST OPERATIVE PHYSICAL THERAPY 12 SESSIONS 3 X WEEK FOR 4 WEEK:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

