

Case Number:	CM14-0107647		
Date Assigned:	08/01/2014	Date of Injury:	11/16/2005
Decision Date:	10/08/2014	UR Denial Date:	06/07/2014
Priority:	Standard	Application Received:	07/11/2014

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 Plastic and Reconstructive Surgery and is licensed to practice in Maryland, Virginia and North Carolina. 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 68 year old male with a reported date of injury on 11/16/05 who requested authorization for right cubital tunnel release. Documentation from 5/15/14 notes that the patient has a new diagnosis for evaluation. He has had symptoms of a right ulnar neuropathy for some time. He describes numbness mostly in the medial aspect (ulnar) of his right hand associated with vascular symptoms and occasional dysfunction (clawing the form of the sign of the "papal benediction") Examination notes negative Tinel's and Phalen's signs at the wrist and elbow. He does have early wasting of the intrinsic muscles of the hand and occasional posture in the hand of the sign of the "Papal benediction". The affected hand is not documented. Electrodiagnostic studies are stated to show bilateral cubital and carpal tunnel compression, but it is important to know that his left arm is chronically affected and the patient is interested in only preserving function in his right arm. Recommendation is made for right cubital tunnel release based on a diagnosis right cubital tunnel syndrome. Documentation from 3/4/14 does not note findings relative to the right upper extremity. Claim status report dated 2/3/14 notes that the AME opinioned that the claimant was unable to work due to spine problems, recurrent infections and multiple operations, the functional non-use of the left upper extremity and the entrapment of neuropathies of the right upper extremity. A Utilization review dated 6/17/14 did not certify right cubital tunnel release. Specific rationale related to this patient was not provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Cubital Tunnel Release (Decompression of the ulnar nerve at the elbow): 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): 37.

Decision rationale: From ACOEM, Elbow complaints, page 37, with respect to ulnar nerve entrapment, 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. Based on the available documentation, there is insufficient medical documentation of a clear right ulnar neuropathy that has failed non-operative treatment and is confirmed by electro-diagnostic studies. If there is in fact intrinsic muscle wasting on the right side and confirmatory electro-diagnostic studies then this may obviate the need for conservative management. However, the medical records provided are not supportive of this. This request is not medically necessary.