Case Number:	CM14-0011974		
Date Assigned:	02/21/2014	**Date of Injury:**	08/16/2010
Decision Date:	06/26/2014	**UR Denial Date:**	01/21/2014
Priority:	Standard	**Application Received:**	01/29/2014

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 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:

This 54-year-old male sustained an industrial injury on 8/16/10. The mechanism of injury was not documented. He is status post left shoulder rotator cuff and decompression surgeries on 6/25/11 and 11/13/12, and left shoulder manipulation, arthroscopic lysis of adhesions, debridement of anterior labral tear, and subacromial decompression on 9/5/13. He sustained a complex tear of the triangular fibrocartilage complex and underwent soft tissue reconstruction with flexor carpi radialis tendon graft on 11/17/11, and subsequent scaphoid excision and four-quadrant intercarpal arthrodesis with left carpal tunnel release on 7/31/12. He underwent left wrist hardware removal surgery on 8/22/13. Past medical history includes diabetes mellitus type II and a diagnosis of probable left arm diabetic neuropathy. Records indicated that 6/2/11 electrodiagnostic study showed borderline slow motor conduction velocity across the elbow and the "inching study" showed prolonged latency consistent with a left ulnar neuropathy across the elbow, i.e. cubital tunnel syndrome. The 12/13/13 treating physician report cited subjective complaints of numbness and tingling in the left ring and little fingers, progressive loss of muscle mass in the left first dorsal interosseous, left wrist and hand stiffness, and swelling left hand fingers. Physical exam findings included 6 mm two-point discrimination to the left little finger, 5 mm to the left ring, long and index fingers, and 6 mm to the left thumb, all radially and ulnarly. There was a positive Tinel's over the left ulnar nerve at the cubital tunnel and very positive left elbow flexion test at 20 seconds. Significant wasting was noted of the left first dorsal interosseous, the other dorsal interossei, the abductor digiti minimi compared to the right hand. Forearm circumference was 27 cm right, 25.5 cm left, and hand circumference was 23.1 cm right and 22.6 cm left. The patient demonstrated more significant flattening of the left palm compared to the normal curvature of the right palm. The diagnosis was left ulnar neuropathy secondary to compression/stretch at the cubital tunnel with constant numbness and tingling of the

left ring and little fingers, and very significant wasting of the ulnar innervated intrinsic muscles of the left hand. The patient had reportedly failed all forms of conservative treatment. The treatment requested is left ulnar nerve decompression at cubital tunnel, with anterior subfascial-submuscular transposition, Z-plasty lengthening of the flexor pronator origin, left medial elbow, placement of long arm sugar tong splint, with PA assistant, and post-op therapy 2x5. The 1/20/14 utilization review denied the surgical request based on the absence of documentation that the ulnar nerve subluxed on range of motion of the elbow and delay nerve conduction velocity.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT ULNAR NERVE COMPRESSION AT CUBITAL TUNNEL, WITH ANTERIOR SUBFASCIAL-SUBMUSCULAR TRANSPOSITION, Z-PLASTY LENGHTENING OF THE FLEXOR PRONATOR ORIGIN, LEFT MEDIAL ELBOW, PLACEMENT OF LONG ARM SUGAR TONG SPLINT, WITH PA ASSISTANT: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, ,

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

Decision rationale: Under consideration is a request for left ulnar nerve decompression at cubital tunnel, with anterior subfascial-submuscular transposition, Z-plasty lengthening of the flexor pronator origin, left medial elbow, placement of long arm sugar tong splint, with PA assistant. The California MTUS elbow guidelines indicate 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. Surgery is recommended in the form of simple decompression for patients with chronic ulnar neuropathy at the elbow who have positive electrodiagnostic studies, objective evidence of loss of function, and lack of improvement with 3 to 6 months of comprehensive conservative treatment. Submuscular transposition has not been shown to be beneficial and is recommended against by the MTUS. Anterior transposition may be supported at the time of attempted decompression if indications are present, but evidence is reported insufficient. The Official Disability Guidelines indicate that transposition is only required if the ulnar nerve subluxes on range of motion of the elbow, otherwise simple decompression is recommended. Guideline criteria have been met. This employee presents with significant subjective and objective findings consistent with left ulnar neuropathy. There are significant left upper extremity activity limitations. There are reported significantly positive electrodiagnostic findings associated with the wasting of the ulnar nerve innervated intrinsic muscles. The choice of transposition vs nerve decompression is within the purview of the treating provider and to be based on the overall findings. In this case; the severity of the findings support the requests according to overall intent of guidelines. Therefore, the request for left ulnar nerve decompression at cubital tunnel, with anterior subfascial-submuscular transposition, Z-plasty lengthening of the flexor pronator origin, left medial elbow, placement of long arm sugar tong splint, with PA assistant is medically necessary.

LEFT ELBOW POST-OP THERAPY 2 X 5: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: POSTSURGICAL TREATMENT GUIDELINES, ,

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 16.

Decision rationale: As the request for left ulnar nerve decompression at cubital tunnel, with anterior subfascial-submuscular transposition, and Z-plasty lengthening of the flexor pronator origin, left medial elbow is medically necessary, the request for left elbow post-op therapy 2x5 is also medically necessary according to the guidelines. Typically,"Post-surgical treatment: 20 visits over 10 weeks" are supported and the request is within guidelines.