

Case Number:	CM14-0128722		
Date Assigned:	09/22/2014	Date of Injury:	06/12/2009
Decision Date:	12/11/2014	UR Denial Date:	07/22/2014
Priority:	Standard	Application Received:	08/13/2014

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:

This 48-year-old male sustained an industrial injury on 6/1/09, due to cumulative trauma. Past surgical history was positive for left cubital tunnel release and bilateral carpal tunnel releases. Records documented multiple pain problems with severe constant pain over his entire body with tingling numbness to the limbs and loss of feeling in the hands and feet. The patient was using braces on both wrists and elbows. Medications included OxyContin, Neurontin, Zanaflex, Naproxen, Colace, Wellbutrin, and Remeron, and helped keep pain tolerable. The 7/9/14 treating physician report cited constant severe bilateral elbow pain with some clicking and popping in both elbows, right worse than left, and constant severe bilateral wrist pain radiating to this elbows. He reported that numbness and tingling in both arms and hands with radiation of pain from his neck. Periodically, the arms would go completely numb. Right elbow exam documented full range of motion, moderate tenderness over the lateral epicondyle, common extensor tendon, and cubital tunnel, and mild to moderate tenderness over the olecranon and the medial epicondyle. There was generalized diffuse tenderness over both wrists, slightly more localized on the palmar side of the wrist and over the carpal tunnel and Guyon's canal. There was breakaway weakness of all the muscles. Tinel's and Phalen's signs were positive at the wrists. The diagnosis include right elbow lateral epicondylitis and common extensor tendinitis and potential cubital tunnel syndrome, and right carpal tunnel syndrome with flexor tenosynovitis status post carpal tunnel release with persistent symptoms and potential impairment of the ulnar nerve in Guyon's canal. The patient was also diagnosed with degenerative disc disease and spondylosis plus stenosis of the cervical spine which was most severe at C6/7 associated with bilateral upper extremity radiculitis. The patient reported that a nerve study had been performed and a cubital tunnel release had been recommended. The treatment plan requested authorization of a right ulnar nerve release with anterior transposition. The treating physician stated that it would be

ideal to obtain a copy of the new nerve study done in June 2014. The 7/22/14 utilization review denied the right elbow ulnar nerve release surgery and associated physical therapy as there was no documentation of failed conservative treatment or current electrodiagnostic findings.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Elbow Ulnar Nerve Release with an Interior Transposition: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 40-43.

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. Guideline criteria have not been met. There is no documentation of the electrodiagnostic findings in the June 2014 study. There is no documentation of current physical exam evidence of ulnar nerve entrapment at the elbow. Evidence of 3 to 6 month(s) of a recent, reasonable and/or comprehensive non-operative treatment protocol trial directed to the right elbow and failure has not been submitted. Therefore, this request is not medically necessary.

Post-Operative Physical Therapy twice per week for six weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 18.

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