

Case Number:	CM14-0165209		
Date Assigned:	10/10/2014	Date of Injury:	10/22/2003
Decision Date:	11/10/2014	UR Denial Date:	09/19/2014
Priority:	Standard	Application Received:	10/07/2014

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:

According to the records made available for review, this is a 57-year-old male with a 10/22/03 date of injury, and right shoulder open distal clavicle resection on 5/13/11. At the time (9/19/14) of the Decision for Right cubital tunnel release, Right shoulder decompression, Pre-operative EKG, Unknown pre-operative labs, and Pre-operative medical clearance, there is documentation of subjective (increasing right shoulder and right elbow pain in the ulnar nerve distribution associated with numbness and tingling) and objective (decrease shoulder and elbow range of motion with pain, positive Tinel's sign, and decreased sensation on the ulnar nerve distribution) findings, current diagnoses (ulnar nerve lesion), and treatment to date (medications and cortisone injections). Medical report identifies that the patient has shoulder pain at night and wakes the patient up from sleep. Regarding cubital tunnel release, there is no documentation of failure of additional conservative treatment (pad/splint for a 3 month trial period); and delayed NCV. Regarding shoulder decompression, there is no documentation of positive impingement sign and imaging findings showing positive evidence of deficit in rotator cuff.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right cubital tunnel release: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 37. Decision based on Non-MTUS Citation Official Disability Guidelines-Elbow (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 37. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow Chapter, Surgery for Cubital Tunnel Syndrome (Ulnar Nerve Entrapment)

Decision rationale: MTUS reference to ACOEM guidelines identifies documentation of positive electrodiagnostic studies with objective loss of function and lack of improvement with conservative care, as criteria necessary to support the medical necessity of simple decompression of the ulnar nerve. ODG identifies documentation of subjective/objective findings consistent with ulnar neuropathy, significant activity limitations, delayed NCV, and failure of conservative treatment (exercise, activity modification, medications, and pad/splint for a 3 month trial period), as criteria necessary to support the medical necessity of simple decompression of the ulnar nerve. Within the medical information available for review, there is documentation of a diagnosis of ulnar nerve lesion. In addition, given documentation of subjective (right elbow pain in the ulnar nerve distribution associated with numbness and tingling) and objective (decreased elbow range of motion with pain, positive Tinel's sign, and decreased sensation on the ulnar nerve distribution), there is documentation of subjective/objective findings consistent with ulnar neuropathy and significant activity limitations. However, despite documentation of conservative treatment (medications and corticosteroid injections), there is no documentation of failure of additional conservative treatment (pad/splint for a 3 month trial period). In addition, there is no documentation of delayed NCV. Therefore, based on guidelines and a review of the evidence, the request for Right Cubital Tunnel Release is not medically necessary.

Right shoulder decompression: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Subacromial Decompression and Manipulation Under Anesthesia

Decision rationale: MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. ODG identifies documentation of conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases); objective clinical findings: weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test); imaging clinical findings: conventional x-rays, AP, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of a diagnosis of ulnar nerve lesion. In

addition, there is documentation of failure of conservative treatment (medications and cortisone injection). However, despite documentation of subjective (increasing right shoulder pain in the ulnar nerve distribution associated with numbness and tingling and shoulder pain at night) and objective (decrease shoulder and elbow range of motion with pain findings, there is no documentation of positive impingement sign and imaging findings showing positive evidence of deficit in rotator cuff. Therefore, based on guidelines and a review of the evidence, the request for Right Shoulder Decompression is not medically necessary.

Pre-operative EKG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement, Preoperative evaluation

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.

Unknown pre-operative labs: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, California Official Medical Fee Schedule, Pages 92-93

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.

Pre-operative medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, California Official Medical Fee Schedule, Pages 92-93

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.