Case Number:	CM14-0180778		
Date Assigned:	11/05/2014	**Date of Injury:**	01/20/1998
Decision Date:	12/12/2014	**UR Denial Date:**	10/22/2014
Priority:	Standard	**Application Received:**	10/30/2014

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:

Medical records from 2013 to 2014 were reviewed. Patient complained of left-sided neck and shoulder pain with radiation into the left 4th and 5th digits. She had difficulty picking up things. Patient likewise complained of left elbow pain. Examination of the left elbow showed tenderness without swelling, warmth, and instability of medial, ulnar, and radial collateral ligaments. Range of motion was full. She had slightly enlarged ulnar nerve in the medial epicondylar groove. Peripherally, there was atrophy of the intrinsics and weakness of first dorsal interosseous, abductor digiti minimi, and dorsal interossei. She had vasomotor changes with hyperhidrosis in the ulnar nerve distribution with sensory loss. Both Tinel's and Phalen's signs were positive. She also had a tear in the ulnar collateral ligament of the metacarpophalangeal joint of the thumb. EMG/NCV from 4/20/2011 showed mild left ulnar motor neuropathy at the elbow without evidence of denervation in the distal ulnar innervated muscles; no evidence of left carpal tunnel syndrome; and no evidence of left upper extremity entrapment neuropathy. Treatment to date has included neurectomy of the right foot, anterior cervical fusion, lumbar fusion and laminectomy, right knee arthroscopy, right shoulder arthroscopy, Mumford resection and removal of enchondroma from the humerus, physical therapy, bracing, and medications. Utilization review from 9/2/2014 denied the request for left elbow ulnar nerve decompression because mild findings of EMG/NCV did not correlate well with the significant symptoms experienced by the patient. An updated electrodiagnostic testing should initially be ordered to assess progression of her condition.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left elbow ulnar decompression: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow chapter, Surgery for cubital tunnel syndrome (ulnar nerve entrapment)

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG) was used instead. For cubital tunnel syndrome, simple decompression is recommended in most cases. Surgical transposition of the ulnar nerve is not recommended unless the ulnar nerve subluxes on ROM of the elbow. Initial conservative treatment including strengthening exercises, activity modification, medications, and use of a pad/night splint for at least 3 months is necessary prior to surgery. In this case, patient complained of chronic left-sided neck and shoulder pain with radiation into the left 4th and 5th digits. Patient likewise complained of left elbow pain. EMG/NCV from 4/20/2011 showed mild left ulnar motor neuropathy at the elbow without evidence of denervation in the distal ulnar innervated muscles; no evidence of left carpal tunnel syndrome; and no evidence of left upper extremity entrapment neuropathy. However, symptoms persisted despite conservative measures involving physical therapy, bracing, and medications. The most recent physical examination of the left elbow showed tenderness and a slightly enlarged ulnar nerve in the medial epicondylar groove. Peripherally, there was atrophy of the intrinsics and weakness of first dorsal interosseous, abductor digiti minimi, and dorsal interossei. She had vasomotor changes with hyperhidrosis in the ulnar nerve distribution with sensory loss. Both Tinel's and Phalen's signs were positive. She also had a tear in the ulnar collateral ligament of the metacarpophalangeal joint of the thumb. Given that patient's condition has worsened despite initial management, surgery may be a reasonable treatment option at this time. Clinical manifestations are likewise consistent with ulnar nerve entrapment at the elbow. Therefore, the request for left elbow ulnar nerve decompression is medically necessary.