

<b>Case Number:</b>	CM14-0021911		
<b>Date Assigned:</b>	05/16/2014	<b>Date of Injury:</b>	01/28/2011
<b>Decision Date:</b>	07/11/2014	<b>UR Denial Date:</b>	02/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/21/2014

### 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 and Hand Surgery, and is licensed to practice in Texas. 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:

The injured worker is a 36-year-old female who reported injury on 01/28/2011. The diagnoses included right elbow cubital tunnel syndrome. The mechanism of injury was the injured worker was working as a medical assistant and was called by another co-worker to help a patient who already had difficulty standing. The employee put her right arm under the patient and the patient went limp again and his weight came down on the injured worker's right side on her shoulder and bent her right wrist. The injured worker was treated with physical therapy. The injured worker underwent a right wrist arthroscopy on 12/21/2011 with 24 sessions of postoperative physical therapy and a right wrist arthroscopy again on 09/26/2012. The injured worker underwent an EMG/NCV study on 01/22/2014. The documentation of 12/11/2013 revealed that the injured worker had moderate to severe tenderness over the ulnar, TFCC, SL interval, and ECU tendon in the 6th COMPT. The injured worker had a positive Tinel's test in the median and ulnar side of the right hand, right wrist and right elbow. The documentation indicated the injured worker underwent an MRI of the right wrist with contrast on 02/19/2013 which revealed possible partial tear degeneration along the TFCC peripheral attachment, SL and LT ligaments appeared intact. The ECU had tenosynovitis and partial tearing. The chondral surfaces appeared intact. The documentation indicated the injured worker had an EMG/NCV of the right upper extremity in 07/2011 which revealed no abnormalities. The treatment plan included electrodiagnostic studies, wearing splints, casting or slings.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RIGHT ELBOW CUBITAL TUNNEL RELEASE:** 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): 45, 46.

**Decision rationale:** The ACOEM Guidelines indicate that the referral for a surgical consultation is appropriate for injured workers who have significant limitation of activity for more than 3 months, failure to improve with exercise programs to increase range of motion and strength of the musculature around the elbow and clear clinical and electrophysiologic or imaging evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. Surgery for ulnar nerve entrapment requires established diagnosis on the basis of clear clinical evidence and positive electrodiagnostic studies that correlate with the clinical findings. There should be documentation that the injured worker has failed conservative care, including full compliance in therapy, the use of elbow pads, removing opportunities to rest the elbows on the ulnar groove, work station changes, and avoiding nerve irritation at night by preventing prolonged elbow flexion while sleeping. There should be documentation of positive findings on electrodiagnostic studies. There were objective findings to support the requested surgery. However, the injured worker had an EMG which was normal and there was a lack of documentation of a failure of conservative care including the above recommendations. Given the above, the request for right elbow cubital tunnel release is not medically necessary.