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| Case Number: | CM14-0026482 | | |
| Date Assigned: | 06/13/2014 | Date of Injury: | 04/12/2012 |
| Decision Date: | 07/31/2014 | UR Denial Date: | 02/05/2014 |
| Priority: | Standard | Application Received: | 03/03/2014 |

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 Orthopaedic 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 36-year-old male mechanic/welder sustained an industrial injury on 4/12/12. Injury occurred when a [REDACTED] blade jammed while cutting a muffler, and he forcefully slammed his elbow into the car hoist. The diagnosis was left elbow ulnar nerve contusion with lateral epicondylitis. The 1/14/13 MRI showed possible lateral epicondylitis tendinopathy, conjoined extensor tendon, and small left elbow effusion. The 3/6/13 left upper extremity EMG/NCV was normal. The 4/18/13 treating physician note stated the patient had been unable to slow down his activities as recommended. Physical exam documented paresthesias and numbness in the ulnar nerve distribution, pain in the cubital tunnel, positive Tinel's, and pain and radiating numbness with hyperflexion or held flexion of the elbow. A cubital tunnel release with ulnar nerve transposition was recommended. Conservative treatment had included physical therapy, activity modification, anti-inflammatories, and stretching exercises. The 7/16/13 QME report recommended a left lateral epicondyle injection and, if that was not effective, then he would be a surgical candidate for an arthroscopic release of the lateral extensor mass. Additionally, a corticosteroid injection was recommended about the ulnar nerve, into the cubital tunnel. If that did not provide benefit, he would become a candidate for an arthroscopic release in situ of the ulnar nerve. Medial and lateral epicondyle injections were performed to the left elbow on 10/1/13. The 1/14/14 treating physician report cited continued left elbow pain and discomfort with numbness and paresthesias in the ulnar distribution. An injection on the lateral epicondyle was performed 2 to 3 months ago as recommended by the QME. The injection did help with the lateral epicondyle inflammation, but did not do anything for the ulnar nerve issues. The treatment plan recommended moving forward with a cubital tunnel release with ulnar nerve transposition. The 2/4/14 utilization review denied the request for left cubital tunnel release surgery and post-op physical therapy based on QME recommendations and absent positive electrical studies.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT ELBOW CUBITAL TUNNEL RELEASE WITH ULNAR NERVE

TRANSPOSITION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 37.

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. The electrodiagnostic studies did not demonstrate ulnar neuropathy. There is no detailed documentation that guideline-recommended conservative treatment has been tried and failed. There is no documentation of the use of elbow pads or prevention of prolonged elbow flexion. The patient had reportedly not been completely compliant with activity modifications recommended by the treating physician. There is no documentation that the cubital tunnel injection, recommended by the QME was provided. Therefore, this request for Left Cubital Tunnel Release with Ulnar Nerve Transposition is not medically necessary.

POST-OPERATIVE PHYSICAL THERAPY 2 TIMES A WEEKS FOR 4 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): 16.

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