

Case Number:	CM14-0037224		
Date Assigned:	06/25/2014	Date of Injury:	01/02/2012
Decision Date:	07/23/2014	UR Denial Date:	03/05/2014
Priority:	Standard	Application Received:	03/27/2014

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 Family Medicine, and is licensed to practice in New Jersey. 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:

The worker is a 40-year-old female who was injured on 1/2/12. She later was diagnosed with chronic right and left elbow pain related to cubital tunnel syndrome (ulnar neuritis), and atypical complex regional pain syndrome. She had been treated with elbow brace, ganglion blocks, neuropathic pain medication, and topical analgesics for an unknown duration of time. Her right elbow seemed to be worse than the left according to the record, but her overall pain level was rated at a 6/10 on the pain scale. MRI of the elbows was done on 12/20/13 which was normal, as well as EMG nerve testing from 3/13 which confirmed mild bilateral cubital tunnel syndrome . She was seen by her treating physician on 1/2/14 reporting her left and right elbow pain that radiates down her arms to her fingers, associated with numbness and tingling. Physical examination was remarkable for positive Tinel's along right cubital tunnel (but not left), mild hypothenar and atrophy in the right hand. She was treated with an elbow brace, topical analgesics, physical therapy, and was recommended she receive bilateral injected ulnar nerve blocks with steroids.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Ulnar nerve blocks with ultrasound guidance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) , 2014, Elbow.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 18-19. Decision based on Non-MTUS Citation Hong CZ et. al., Splinting and local steroid injection for the treatment of ulnar neuropathy at the elbow: clinical and electrophysiological evaluation, Arch Phys Med Rehabil., 1996 (<http://www.ncbi.nlm.nih.gov/pubmed/8831474>).

Decision rationale: The MTUS ACOEM recommends a few conservative treatments for ulnar nerve entrapment (including cubital tunnel syndrome): elbow padding, avoidance of leaning on the ulnar nerve at the elbow, avoidance of prolonged hyperflexion of the elbow, and possibly NSAIDs, although quality evidence is lacking for each of these. Injections with steroids or nerve block agents were not among this list as recommended for non-surgical treatment. There is very limited evidence for or against the procedure of steroid injections for ulnar nerve entrapment. Many guidelines simply suggest conservative treatments and if the patient fails, then consider surgical intervention. In general, injections done around the ulnar nerve are invasive and there is some risk of damaging the nerve. One study, albeit older and with a low number of participants, compared splinting with injection and found that at 6 months, there was essentially no difference in outcome, suggesting perhaps in the general population conservative measures over many months is recommended over injections. Based on examination and EMG findings, the worker seems to have ulnar entrapment syndrome causing her pain. She was recommended to use an elbow brace, but it is not known how she used it or for how long, according to the records provided. With very limited quality studies suggesting safety and efficacy for this condition, it is in the opinion of the reviewer that the ulnar nerve blocks are not medically necessary, and either conservative therapy should be continued or surgical consultation requested (depending on the extent of the trial of conservative treatment).

Orthopedic consultation and treatment for the left elbow: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation ODG, 2014, Elbow.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 127, 15, 35, 37.

Decision rationale: The MTUS/ACOEM Guidelines state that referral to a specialist(s) may be warranted if a diagnosis is uncertain, or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise in assessing therapeutic management, determination of medical stability, and permanent residual loss and/or examinee's fitness for return to work, and suggests that an independent assessment from a consultant may be useful in analyzing causation or when prognosis, degree of impairment, or work capacity requires clarification. For the elbow, the ACOEM states that referral is indicated if the health care provider has a lack of training in managing the specific entity, is uncertain about the diagnosis or treatment plan or if there are red flags present. If symptoms or restrictions persist beyond 4-6 weeks, referral may be indicated to assist. Referral for surgery of the elbow may be indicated for patients who have significant limitations of activity for more than 3 months, failed to improve with exercise programs, or 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 establishing a firm diagnosis on the basis of clear clinical evidence and positive electrical studies that correlate with clinical findings. In this case, it is clear that her diagnosis of ulnar entrapment will require treatment, but it is unknown if she has exhausted conservative treatments and for how long or how well she had been attempting them. However, even though conservative treatment may be still the appropriate choice of care for this worker (unknown based on lack of information provided), seeking at least the opinion of the orthopedic surgeon is appropriate and medically necessary.