

Case Number:	CM14-0061087		
Date Assigned:	07/09/2014	Date of Injury:	02/01/2013
Decision Date:	09/10/2014	UR Denial Date:	04/01/2014
Priority:	Standard	Application Received:	05/01/2014

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 50-year-old male chef sustained an industrial injury on 2/1/13, relative to repetitive work duties. The 8/26/13 initial orthopedic report cited constant moderate to severe bilateral elbow pain with numbness in the fingers. The patient had been treated with tennis elbow bands and physical therapy without relief. Elbow exam documented tenderness to palpation over the medial and lateral epicondyles bilaterally. Range of motion was symmetrical with negative pivot shift and varus/valgus testing. Tinel's sign was positive bilaterally. X-rays showed evidence of mild bilateral elbow arthritis. An EMG was recommended as there were signs of cubital tunnel syndrome. The 2/10/14 orthopedic report indicated the patient had been authorized for an unknown surgery with a previous physician prior to his relocation. The patient had EMG/NCV studies but the results were not available. Bilateral elbow exam documented tenderness over the medial and lateral epicondyles with positive Tinel's sign. The treatment plan recommended obtaining records from the prior physician. The 2/26/14 orthopedic report cited constant bilateral elbow pain that was a dull ache with increased activity. EMG/NCV findings were not available. Physical exam noted medial and lateral epicondylar tenderness, normal range of motion, and negative pivot shift and varus/valgus testing. The treatment plan recommended surgery for bilateral medial epicondylitis and ulnar nerve release. The 3/5/14 treating physician report cited no change in symptoms. Bilateral elbow exam documented medial and lateral epicondylar tenderness, normal range of motion, and no crepitus. The diagnosis was bilateral lateral and medial epicondylitis. The patient was capable of modified work with lifting, pushing and pulling limited to 30 pounds. The 4/1/14 utilization review denied the request for left elbow Nirschi procedure with ulnar nerve release as there was no documentation of conservative treatment response or nerve conduction studies. Subsequent records suggest the Nirschi procedure had

been approved but not the ulnar nerve release. There are no electrodiagnostic study findings documented in the records available for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nirschi procedure with ulnar nerve release, left elbow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM-
<https://www.acoempracguides.org/Elbow>.

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

Decision rationale: The California MTUS updated ACOEM elbow guidelines state that surgery for lateral epicondylalgia should only be a consideration for those patients who fail to improve after a minimum of 6 months of care that includes at least 3-4 different types of conservative treatment. 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. There is no documented electrodiagnostic evidence supported by clinical findings of ulnar nerve entrapment. There is no detailed documentation that comprehensive guideline-recommended conservative treatment relative to the ulnar nerve entrapment had been tried and failed. Therefore, this request is not medically necessary.