

<b>Case Number:</b>	CM14-0065205		
<b>Date Assigned:</b>	09/23/2014	<b>Date of Injury:</b>	12/21/1995
<b>Decision Date:</b>	10/22/2014	<b>UR Denial Date:</b>	05/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2014

### 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:

This 49-year-old male sustained an industrial injury on 12/21/95. The mechanism of injury was not documented. Past medical history was positive for type 2 diabetes mellitus. The 12/3/13 treating physician letter indicated that there was an identifiable anatomic situation that resulted in additional trauma to the ulnar nerves bilaterally. There was on-going ulnar nerve irritation from the subluxation in and out of the cubital tunnels. The patient had undergone prior ulnar nerve decompressions but that did not solve the problem of the nerves popping back and forth over the medial epicondyles. The ulnar nerves were not stable in the cubital tunnels and translated anteriorly with the subluxation producing regular and repetitive ulnar nerve trauma. The correction would be transposition of the ulnar nerve and not just release. The left side is the major problem and would be dealt with first, followed by the right side. There was severe ulnar neuropathy bilaterally and on-going/continuing trauma to the nerves at the elbows secondary to subluxation. This situation threatened what nerve function was left. The injuries sustained were already debilitating. The treating physician opined the medical necessity to protect the remaining hand function bilaterally. There was continued pain and paresthesia on cubital tunnel ulnar subluxation. Bilateral ulnar nerve transposition was recommended. The patient subsequently underwent anterior transposition of the ulnar nerve of the left elbow on 1/24/14. The 4/7/14 treating physician report indicated the patient was status post left ulnar nerve transposition with excellent results on the left and on-going problems with the right ulnar nerve at the cubital tunnel. The patient had done very well post-operatively with good left elbow range of motion, normal Froment's test, dramatically better finger abduction and adduction, and the return of sensation in the ulnar distribution on the left. The right side was reported as a mirror image of the left. The treating physician opined that the results on the left proved his supposition that continued on-going trauma to the ulnar nerves was an underlying and repetitive cause for some

of the persistent disability. Request for authorization of right ulnar nerve transposition was submitted. The 5/1/14 utilization review denied the request for right ulnar nerve transposition as there was no mention of carpal tunnel syndrome. The 6/2/14 treating physician appeal letter stated that despite electrical abnormalities on the right, the carpal tunnel was not significantly symptomatic. Surgery to the ulnar nerve on the right was recommended to alleviate the continuing source of trauma to the nerve.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Ulnar nerve transposition for right elbow:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

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

**Decision rationale:** The California MTUS guidelines state that quality studies are available on anterior transposition for chronic ulnar nerve entrapment at the elbow. In well-defined, but infrequent cases that include positive electrodiagnostic studies with objective evidence of loss of function, this may be a reasonable option at the time of attempted decompression. Guideline criteria have been met. This patient is status post decompressive surgery with continued movement of the ulnar nerve in and out of the cubital tunnel causing on-going nerve trauma and debilitating symptoms. He was diagnosed with severe ulnar neuropathy. An identical situation on the left side has had dramatic improvement in the patient's functional status with anterior transposition surgery. Given the failures of non-operative and operative treatment, this request seems reasonable and consistent with guidelines. Therefore, this request is medically necessary.