

<b>Case Number:</b>	CM14-0092278		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	08/03/2010
<b>Decision Date:</b>	09/29/2014	<b>UR Denial Date:</b>	05/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/18/2014

### 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 Montana. 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 injured worker is a 56 year old female clerical worker who reported a repetitive trauma injury to the bilateral upper extremities including the elbows on 8/3/10. She was diagnosed with left cubital tunnel syndrome based on clinical examination and 10/13/10 electrodiagnostic testing which demonstrated mild left cubital tunnel syndrome. The formal electromyography (EMG)/nerve conduction test (NCT) report was not provided. The injured worker was treated with physical therapy (PT), no steroidal anti-inflammatory drugs (NSAIDs), Nortriptyline, steroid injections to undocumented areas and activity modification. She was placed at permanent and stationary status on 2/14/13. Electrodiagnostic testing of the right upper extremity, but not the left, was documented in a formal report. More recently, she reports escalating bilateral upper extremity pain from the elbows to the fingers with numbness and paresthesia in the hands, left side more than right (L>R). When evaluated on 2/28/14, she had decreased sensation in the left ulnar nerve distribution of the hand and forearm with tenderness over the left forearm flexors and extensors. There is no documentation of a left elbow examination. A left cubital tunnel release has been recommended.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cubital Tunnel Release Left Elbow:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 45-46.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 16, Postsurgical Treatment Guidelines Page(s): 16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow, Surgery for cubital tunnel syndrome (ulnar nerve entrapment).

**Decision rationale:** The Medical Treatment Utilization Schedule (MTUS) guidelines do not address cubital tunnel release. The American College of Occupational and Environmental Medicine (ACOEM) and the Official Disability Guidelines (ODG) state that there must be documentation of signs and symptoms of cubital tunnel syndrome along with a recent nerve conduction test. There is no documentation of a positive elbow flexion test or Tinel's sign at the cubital tunnel. Although it is stated the injured worker has numbness in the ulnar distribution of the hand, there is no specific documentation of involvement of the forearm consistent with cubital tunnel syndrome. There is no documentation of a trial of left elbow splinting. Per the Official Disability Guidelines (ODG) Indications for Surgery (ACOEM recommendations are similar), surgery for cubital tunnel syndrome: Initial conservative treatment, requiring all of the following: Exercise: Strengthening the elbow flexors/extensors isometrically and isotonicly within 0-45 degrees [This criterion is not met and not documented. Activity modification: Recommend decreasing activities of repetition that may exacerbate the injured worker's symptoms. Protect the ulnar nerve from prolonged elbow flexion during sleep, and protect the nerve during the day by avoiding direct pressure or trauma. [This criterion is not met and no changes in sleeping position are documented. Medications: Non-steroidal anti-inflammatory drugs (NSAIDs) in an attempt to decrease inflammation around the nerve. Pad/splint: Use an elbow pad and/or night splinting for a 3-month trial period. Consider daytime immobilization for 3 weeks if symptoms do not improve with splinting. If the symptoms do improve, continue conservative treatment for at least 6 weeks beyond the resolution of symptoms to prevent recurrence. Absent a complete clinical examination of the left upper extremity, a diagnosis of left cubital tunnel syndrome is not established by the available documentation. Based on lack of documentation of a positive recent nerve conduction test of the left upper extremity and documentation of completion of conservative treatment, left cubital tunnel release left elbow is not medically necessary.