

<b>Case Number:</b>	CM13-0053962		
<b>Date Assigned:</b>	01/22/2014	<b>Date of Injury:</b>	09/09/2009
<b>Decision Date:</b>	05/12/2015	<b>UR Denial Date:</b>	11/05/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/19/2013

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Minnesota, Florida  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 (IW) is a 43 year old female who sustained an industrial injury on 09/09/2009. She reported injury to the elbow. The injured worker was diagnosed as having a left elbow ulnar neuritis and cubital tunnel syndrome with entrapment of ulnar nerve, and left elbow; status post previous failed ulnar nerve transposition (1990's). Treatment had included diagnostic MRI, application of ice and stretching, and work restrictions. The worker was seen on 07/29/2013 for orthopedic re-evaluation of the left elbow and was scheduled for left elbow open cubital tunnel release and anterior ulnar nerve transposition revision surgery. Her subjective complaint was of numbness and tingling involving the ulnar nerve distribution of the left upper extremity. A request for authorization was made specifically for revision surgery of the left elbow consisting of a cubital tunnel release and ulnar nerve transposition which was certified. Associated surgical requests that were modified or noncertified included: 1. Orthopress hanger and CTU wrap of the left elbow; and 2 A 21 day post-operative rental of a continuous passive motion machine and purchase of a cold therapy unit. On October 11, 2013 the injured worker underwent a left elbow cubital tunnel release and anterior transposition revision. The postoperative diagnosis was left elbow ulnar neuritis and cubital tunnel syndrome with entrapment of ulnar nerve, left elbow, status post previous failed ulnar nerve transposition. The current independent medical review pertains to the associated surgical requests.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**21 DAY POST-OPERATIVE RENTAL OF A CONTINUOUS PASSIVE MOTION MACHINE AND PURCHASES OF A COLD THERAPY UNIT: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, ELBOW DISORDERS, 2.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Knee, Topic: Continuous passive motion, continuous flow cryotherapy, Section: Elbow: Topic: Surgery for cubital tunnel syndrome.

**Decision rationale:** ODG guidelines recommend continuous passive motion for knee and shoulder surgery but not for ulnar nerve decompression or transposition at the elbow. As such, the request for continuous passive motion machine rental for 3 weeks is not supported and the medical necessity of the request has not been established. ODG guidelines recommend continuous-flow cryotherapy for the shoulder and knee surgery. Postoperative use is recommended for 7 days. However, it is not recommended for elbow surgery. ODG guidelines indicate that cold packs are recommended for the elbow. As such, the request for a continuous-flow cryotherapy unit purchase for the elbow is not supported and the medical necessity of the request has not been established.

**ORTHOXPRESS HANGER AND CTU WRAP OF THE LEFT ELBOW: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ELBOW DISORDERS, 2.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Elbow, Topic: Splinting, Section: Knee, Topic: Continuous flow cryotherapy.

**Decision rationale:** ODG guidelines recommend splinting of the elbow or a foam pad to be worn at night to limit movement and reduce irritation. The request as stated is for an Orthoexpress-Hanger device and does not specify if this is an orthotic device. If a night splint is required, a molded posterior splint could be easily made for nighttime use. There is no documentation as to why this particular device is necessary. The request does not specify if this is an orthotic device. As such, the request for Orthoexpress-Hanger is not supported and the medical necessity is not established. The CTU wrap is a part of the cold therapy unit which is not recommended. As such, the wrap is also not recommended and the medical necessity is not established.