Case Number:	CM14-0111851		
Date Assigned:	08/06/2014	**Date of Injury:**	01/30/2014
Decision Date:	12/08/2015	**UR Denial Date:**	06/19/2014
Priority:	Standard	**Application Received:**	07/17/2014

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. 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: Illinois, California, Texas 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:

This injured worker is a 53-year-old female who sustained an industrial injury on 1/30/14. Injury occurred while she was driving a truck in heavy winds and the truck turned over on its left side and slid 415 feet. She sustained a grade 3 open fracture-dislocation of the left elbow (ulna and distal humerus) with significant skin, muscle and bone loss. She underwent irrigation and debridement of the left elbow with open packing and splinting on 1/30/14. An open reduction and internal fixation (ORIF) of the proximal ulnar with a plate with repeat debridement and placement of antibiotic-impregnated cement spacers and wound VAC was performed on 2/2/14. She underwent another wound debridement, cement spacer exchange replacement, and application of a split thickness skin graft on 2/4/14. The 3/19/14 left elbow CT scan with 3D reconstruction impression documented status post fixation of the olecranon process with metallic hardware and cement demonstrating persistent linear lucency between the interface of the cement and native olecranon without displacement of the cement or hardware. There was medial subluxation of the olecranon process from the olecranon fossa. There was likely moderate to large joint effusion. The 4/18/14 EMG/NCV was consistent with severe ulnar neuropathy. The 5/1/14 treating physician report cited left elbow nerve pain. She had completed 19 sessions of physical therapy and felt that it was helping. She was taking Motrin for pain. Physical exam documented grip strength as 65/65/65 pounds right and 2/2/0 pounds left. Elbow range of motion was 50-90 degrees with almost full supination and pronation. She had a positive Tinel's sing over the ulnar nerve. Shoulder elevation as 90 degrees, external rotation 30 degrees, and internal rotation to the buttock level. She had diminished sensation in the ulnar nerve distribution with no

small finger distal interphalangeal joint flexion. The diagnosis was status post ORIF left elbow, left ulnar neuropathy with probable ulnar nerve transection, adhesive capsulitis left shoulder, and stiffness left hand. The treatment plan recommended revision open reduction internal fixation left elbow iliac crest versus allograft, exploration of the ulna nerve, and manipulation of the left shoulder and hand. The 6/2/14 initial orthopedic consult report summarized the history of injury and treatment. Subjective complaints included pain and numbness in the ulnar nerve distribution and loss of hand function consistent with physical exam findings. He recommended cable grafts for the ulnar nerve as soon as possible with a specialist and opined that cable nerve grafts took priority over the revision fracture surgery. Specialist referral was recommended for evaluation and treatment with ulnar nerve grafting. The 6/12/14 appeal letter submitted by the treating physician indicated that the fracture was in alignment but had never healed. She had a cement spacer where there was bone loss and required a repeat reduction to provide the application of the bone graft. This needed to be done soon so that the fixation did not fail and create a major reconstruction issue. She had not improved in four months following the injury and had EMG testing suggestive of ulnar nerve resection. Appeal authorization was requested for revision ORIF left elbow iliac crest versus allograft, explore ulna nerve, manipulate left shoulder and hand with associated surgical services, including 12 to 24 post-operative physical therapy session. The 6/17/15 specialist report cited pain in the ulnar nerve distribution. Left upper extremity exam documented a very stiff elbow with 70-100 degrees range of motion, grossly unstable elbow, tenderness about the cubital tunnel ulnarly, positive Tinel's test, and positive elbow hyperflexion test at the cubital tunnel. Sensation was decreased in the ulnar nerve distribution involving the ulnar 1/2 digits of both the dorsal ulnar aspect of the hand. She had no intrinsic muscle function, and no flexor digitorum profundus function at the small and ring fingers. There was intrinsic muscle atrophy. She had a complete ulnar palsy of the left elbow. Records indicated that surgery was planned for 6/30/14 for ulnar nerve exploration, and nerve graft with sural nerve graft from the left lower extremity. She had been certified on 6/18/14 for evaluation and treatment for nerve grafting. The 6/19/14 utilization review modified the 6/16/15 appeal request for revision open reduction internal fixation left elbow iliac crest versus allograft, explore ulna nerve, manipulate left shoulder and hand to revision open reduction internal fixation left elbow iliac crest versus allograft, manipulate left shoulder and hand. The ulnar nerve grafting had been certified with a different surgeon and there was no apparent need for duplication of authorization. The request for 12 to 24 sessions of post-op physical therapy was modified to 8 sessions consistent with Post- Surgical Treatment Guidelines for initial post-op care.

IMR ISSUES, DECISIONS AND RATIONALES

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

Revision open reduction internal fixation Left elbow iliac crest vs. allograft, explore ulna nerve, manipulate Left shoulder & hand: Upheld

Claims Administrator guideline: Decision based on MTUS Elbow Complaints 2007. Decision based on Non-MTUS Citation Official Disability Guidelines, Elbow, Shoulder, and Forearm, Wrist & Hand Chapters, (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Elbow Complaints 2007, Section(s): Ulnar Nerve Entrapment.

Decision rationale: The California MTUS guidelines recommend surgical consideration when there are significant limitation of activity for more than 3 months, failure to improve with exercise programs to increase range of motion and strength of the musculature around the elbow; 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. 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. This injured worker presents with persistent pain and numbness in the left ulnar nerve distribution with loss of hand function. Clinical exam findings were consistent with electrodiagnostic evidence of severe ulnar neuropathy, including muscle wasting. There is evidence of significant loss of range of motion. There was imaging evidence of persistent linear lucency between the interface of the cement and native olecranon with bone loss. Detailed evidence of up to 3 months a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. The 6/19/14 utilization review certified this request for revision ORIF left elbow iliac crest versus allograft, exploration ulna nerve, and manipulation of the left shoulder and hand to revision ORIF left elbow iliac crest versus allograft, and manipulation of the left shoulder and hand. The requested ulnar nerve exploration was non-certified as a duplicate request. Records indicate that a specialist was certified to evaluate the ulnar nerve and provide ulnar nerve cable grafting treatment. There is no compelling rationale to support the medical necessity of additional ulnar nerve surgery at this time. Therefore, this request is not medically necessary.

12-24 Post-operative Therapy Sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, and Postsurgical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines, Physical Therapy Guidelines and the Elbow & Shoulder Chapters(acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009,
Section(s): Elbow & Upper Arm.

Decision rationale: The California Post-Surgical Treatment Guidelines for surgical treatment of fracture of the ulna suggest a general course of 16 post-operative physical medicine visits over 8 weeks, during the 4-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 8 visits. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. If it is determined that additional

functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical period. The 6/19/14 utilization review recommended partial certification of 8 initial post-op physical therapy visits consistent with guidelines. There is no compelling reason submitted to support the medical necessity of care beyond guideline recommendations and the care already certified. Therefore, this request is not medically necessary.