

Case Number:	CM14-0195816		
Date Assigned:	12/03/2014	Date of Injury:	03/17/2011
Decision Date:	01/28/2015	UR Denial Date:	10/22/2014
Priority:	Standard	Application Received:	11/21/2014

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 Minnesota. 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 37-year-old female who sustained injuries to the cervical spine, shoulders, elbows, wrists and hands on March 17, 2011 when a filing cabinet fell forward, landing on top of her. She experienced immediate pain in the neck, back, right shoulder and arm. She was treated with physical therapy. An MRI scan of the right shoulder was performed on May 6, 2011 and revealed acromioclavicular arthritis but no evidence of rotator cuff tear or labral pathology. EMG and nerve conduction study dated July 23, 2014 revealed no evidence of radiculopathy. There was suggestion of right ulnar sensory neuropathy at the elbow. The nerve conduction studies of the lower extremities were normal. Past medical history was negative for hypertension, diabetes, lung disease, epilepsy, tuberculosis, collagen disease, cancer, or arthritis. The only positive finding was a thyroid condition. X-rays of the cervical spine revealed mild degenerative changes. X-rays of the lumbar spine were said to be negative. Examination of the right elbow on August 15, 2014 revealed a positive Tinel's over the cubital tunnel and full range of motion of the elbow associated with pain complaints. There was no clinical evidence of instability. There was no swelling. Sensation was diminished over the ulnar digits. A request for right cubital fossa release with concurrent medial epicondylar release was modified by utilization review to certify a simple decompression of the ulnar nerve. A request for medical clearance with an internist was modified to certification of CBC and CMP and urinalysis on 10/21/2014. The modified requests have now been appealed to independent medical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post operative physical therapy, three times a week for four weeks for the right arm:
Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Right cubital fossa release with concurrent medial epicondylar release: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 36-37.

Decision rationale: The documentation provided indicates a cubital tunnel syndrome confirmed by electrodiagnostic studies. California MTUS guidelines indicate a simple ulnar nerve decompression is superior to anterior transposition and the complication rate is much less. The guidelines state that quality studies are not available on surgery for medial epicondylalgia. Some information suggests surgical outcomes for medial epicondylalgia may be somewhat worse when compared to lateral epicondylalgia. There are moderate side effects. Therefore surgery for the medial epicondyle 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. Therefore the requested medial epicondylar release is not recommended. However, simple decompression of the ulnar nerve is likely to be successful and the additional surgery for the medial epicondyle may not be necessary.

Medical clearance with internist: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.