

<b>Case Number:</b>	CM15-0145880		
<b>Date Assigned:</b>	08/07/2015	<b>Date of Injury:</b>	12/18/2014
<b>Decision Date:</b>	09/03/2015	<b>UR Denial Date:</b>	07/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/28/2015

### 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 39-year-old male who sustained an industrial injury on 12/18/14. Injury occurred when he was applying downward pressure on a device that pushed back with such great force that he was lifted into the air and fell, landing on his left neck and shoulder. Conservative treatment was documented to include physical therapy, medications, and activity modification. The 3/24/15 left shoulder MR arthrogram impression documented mild to moderate degenerative change of the left acromioclavicular (AC) joint with some narrowing of the acromiohumeral interval without evidence of rotator cuff degeneration or tear. The 5/29/15 treating physician report cited continued sharp left shoulder pain with reaching overhead ranging from grade 3-6/10. He had completed therapy with better mobility but continued pain. He had numbness and tingling in the left hand involving the 4th and 5th fingers. Left shoulder exam documented diffuse lateral tenderness, anterior tenderness over the biceps tendon, no AC joint tenderness, flexion to 170 degrees, and abduction to 160 degrees. There was positive Tinel's at the cubital tunnel on the left, decreased sensation 4th and 5th fingers, and increased numbness and tingling in the 4th and 5th digits with elbow flexion. The diagnosis included shoulder impingement syndrome, brachial plexus injury, and cubital tunnel syndrome. The treatment plan recommended EMG/NCV, continued therapy, and modified work. The 6/16/15 electrodiagnostic study conclusion documented left cubital tunnel syndrome based upon slowing on ulnar short segment studies, and no evidence of radiculopathy, generalized peripheral neuropathy, flexopathy, myopathy, or anterior horn cell disease. The 6/29/15 treating physician report documented continued numbness and tingling of the 4th and 5th findings with positive EMG/NCV findings for cubital tunnel syndrome. Authorization was requested for left

decompression ulnar nerve and flexorplasty of the elbow. The 7/8/15 utilization review non-certified the request for decompression of the ulnar nerve as there was no evidence of completion of guideline- recommended treatment. Flexorplasty was non-certified as physical exam findings did not support the medical necessity of this request.

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

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

#### **Decompression of Ulnar nerve, flexor plasty of Left elbow: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

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

**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 electro physiologic 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. Guideline criteria have not been met. This injured worker presents with numbness and tingling into the left 4th and 5th digits. Clinical exam findings are consistent with electrodiagnostic evidence of cubital tunnel syndrome. There is no evidence of elbow flexion weakness or loss of elbow range of motion. Detailed evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, consistent with guidelines, and failure has not been submitted. Therefore, this request is not medically necessary at this time.