

Case Number:	CM15-0204388		
Date Assigned:	10/21/2015	Date of Injury:	09/20/2012
Decision Date:	12/09/2015	UR Denial Date:	10/02/2015
Priority:	Standard	Application Received:	10/19/2015

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: Maryland, Virginia, North Carolina
 Certification(s)/Specialty: Plastic 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 is a 36 year old female, who sustained an industrial injury on 9-20-2012. The injured worker is undergoing treatment for: medical epicondylitis, bilateral ulnar neuritis with in situ decompression. On 9-21-15, she reported bilateral upper extremity pain. The AME report indicated that on 4-28-14, electrodiagnostic studies revealed axonal ulnar nerve pathology, and median nerve pathology or radial nerve pathology; electrodiagnostic studies on 11-4-14 revealed no evidence of left cervical root, brachial plexus or peripheral nerve entrapment syndromes; and electrodiagnostic studies on 5-8-15 revealed normal results. Physical examination revealed the elbows to have no swelling, residual pain over the cubital tunnel left more than right, positive tinel's at the left elbow, tenderness at the left elbow, equal range of motion bilateral elbows, and normal strength of the elbows. On 9-24-15, the provider noted she has what "appears to be a component of ulnar nerve entrapment with symptoms of pain, tingling and numbness in the little and ring finger. In addition, she has pain in the area of the medial epicondyle". The treatment and diagnostic testing to date has included: splinting, topical creams, multiple injections, AME (9-21-15), electrodiagnostic studies (2012 and 4-28-14), multiple physical therapy sessions, left elbow surgery (12-3-13). Medications have included: none documented. Current work status: modified. The request for authorization is for: median epicondylar release, left upper extremity possible ulnar nerve decompression. The UR dated 10-2-2015: non-certified the request for median epicondylar release, left upper extremity possible ulnar nerve decompression. The patient is noted to have undergone left ulnar nerve release at the elbow on 6/17/14 with temporary relief of her symptoms for approximately 1 month. Documentation from 9/24/15 noted that the patient

has “been treated for several months now nonsurgically for the medial epicondylitis.” Agreed Medical Examination dated 9/21/15 noted that the patient has a residual compression neuropathy of the ulnar nerves. “The patient's condition of the upper extremities is relatively stable and she does not require any active medical treatment other than regular stretching, medications and intermittent bracing. Certainly additional surgery is neither indicated nor likely to be required in the future.” The patient is considered permanent and stationary for rating purposes.

IMR ISSUES, DECISIONS AND RATIONALES

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

Median Epicondylar release, left upper extremity with possible ulnar nerve decompression:
Upheld

Claims Administrator guideline: Decision based on MTUS Elbow Complaints 2007, Section(s): Ulnar Nerve Entrapment, Medial Epicondylalgia.

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

Decision rationale: The patient is a 36 year old female with evidence of left medial epicondylitis and possible residual ulnar neuropathy at the elbow. With respect to medical epicondylitis, the patient is noted to have undergone conservative management over several months. This has included splinting, steroid injection and topical analgesia. A specific physical therapy program of the elbow has not been documented. ACOEM guidelines recommend 6 months of conservative care as follows: Quality studies are not available on surgery for medial epicondylalgia. As noted previously, it is recommended that treatment for medial epicondylalgia be inferred from lateral epicondylalgia; however, some anecdotal information suggests surgical outcomes for medial epicondylalgia may be somewhat worse. This option is high cost, invasive, and has moderate side effects. Thus, surgery for medial epicondylalgia 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. However, there are unusual circumstances in which, after 3 months of failed conservative treatment, surgery may be considered. Therefore, as a comprehensive conservative program including physical therapy over a six month period has not been documented and that AME does not support surgical intervention, medial epicondylar release should not be considered medically necessary. With respect to ulnar nerve decompression, the following guidelines are used: From ACOEM, Chapter 10, page 18 and 19, the following is stated with respect to cubital tunnel syndrome: Aside from surgical studies, there are no quality studies on which to rely for treatment of ulnar neuropathies, and there is no evidence of benefits of the following treatment options. However, these options are low cost, have few side effects, and are not invasive. Thus, while there is insufficient evidence, these treatment options are recommended: Elbow padding [Insufficient Evidence (I), Recommended]; Avoidance of leaning on the ulnar nerve at the elbow [Insufficient Evidence (I), Recommended]; Avoidance of prolonged hyperflexion of the elbow [Insufficient Evidence (I), Recommended]; and Although not particularly successful for neuropathic pain, utilization of NSAIDs [Insufficient Evidence (I), Recommended]. From page 27, "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. Before proceeding with surgery, patients must be apprised of all possible complications, including wound infections, anesthetic complications, nerve damage, and the high possibility that surgery will not relieve symptoms. Absent findings of severe neuropathy such as muscle wasting, at least 3-6 months of conservative care should precede a decision to operate." As there are no supporting EDS and that a 3-6 month trial of the recommended conservative management has not been documented (and surgical intervention is not supported by AME), ulnar nerve decompression at the elbow should not be considered medically necessary.