

Case Number:	CM15-0207795		
Date Assigned:	10/27/2015	Date of Injury:	02/20/2012
Decision Date:	12/08/2015	UR Denial Date:	10/14/2015
Priority:	Standard	Application Received:	10/21/2015

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 54 year old male who sustained an industrial injury on 2-20-12. The medical records indicate that the injured worker has been treated for left carpal tunnel syndrome; left ulnar neuropathy; subluxation of the ulnar nerve at the elbow; medial epicondylitis. He currently (9-29-15) complains of constant left elbow pain. Physical exam revealed ulnar nerve subluxes at the elbow, muscle atrophy at the first dorsal. The 5-29-15 note indicates his epicondylitis symptoms are best controlled with conservative methods. "He does not need surgery at this time." Diagnostics include needle electromyography of the left upper extremity (6-23-14) abnormal; MRI (results noted in the 5-19-15 note) demonstrates a "low grade partial tear of the common flexor tendon origin. This finding is consistent with medial epicondylitis." Treatments to date include status post release of the ulnar nerve at the elbow, medial epicondylectomy, release of median nerve at the wrist; release of ulnar nerve in Guyon's canal (8-26-14); arm compression wrap; medication: Advil. The request for authorization dated 10-7-15 was for anterior transposition of the left ulnar nerve, elbow; electromyography-nerve conduction study left elbow. On 10-14-15 Utilization Review non-certified the requests for anterior transposition of the left ulnar nerve, elbow; electromyography-nerve conduction study left elbow, modified to nerve conduction velocity study, left elbow.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior transposition of left ulnar nerve, elbow: Upheld

Claims Administrator guideline: Decision based on MTUS Elbow Complaints 2007.

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

Decision rationale: The patient is a 54 year old with signs and symptoms of a possible recurrent left elbow entrapment neuropathy. The patient had previously undergone release of the ulnar nerve at the elbow and the wrist on 8/26/14. The patient had undergone electrodiagnostic studies dated 10/27/15 noting normal nerve conduction velocities of the ulnar nerve but ongoing denervation in the ADM and FDI muscles suggesting an ulnar neuropathy. The patient was noted on examination to have subluxation of the ulnar nerve at the elbow and to have 1st dorsal muscle atrophy. Previous electrodiagnostic study from June 23, 2014 noted left ulnar neuropathy affecting both the ulnar sensory and motor fibers. Recommended conservative management has not been documented. 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." The relevant surgical options are discussed: Simple Decompression Quality studies 118, 119, 121, 122 of patients with chronic ulnar neuropathy at the elbow are available on surgical treatment for ulnar nerve entrapment at the elbow. Surgical options for this problem are high cost, invasive, and have side effects. Yet, in well defined but infrequent cases as outlined above that include positive electrodiagnostic studies with objective evidence of loss of function, lack of improvement may necessitate surgery and surgery for this condition is recommended. Compared with more complex procedures, there is evidence of benefits from simple decompression and this procedure is recommended [Evidence (C), Recommended]. Submuscular Transposition Quality studies 121, 122 are available on submuscular transposition. Submuscular transposition has not been shown to be beneficial. This surgical option for this problem is high cost, invasive, and has side effects. Thus, submuscular transposition is not recommended [Evidence (C), Recommended Against]. Anterior Transposition Quality studies 118, 119, 120 are available on anterior transposition for chronic ulnar nerve entrapment at the elbow. Studies show that while effective, the complication rate is higher than for simple decompression. Surgical options for this problem are high cost, invasive, and have side effects. Yet, in well-defined but infrequent cases that include positive electrodiagnostic studies with objective evidence of loss of function where at time of attempted decompression, indications

are felt to be present necessitating anterior transposition, this may be a reasonable option. Thus, subject to these caveats, anterior transposition is recommended [Insufficient Evidence (I), Recommended]. Based on the entirety of the medical documentation, the patient has evidence of a possible ulnar entrapment neuropathy at the elbow, considering the recent electrodiagnostic studies. However, the nerve conduction velocities were normal while the muscle was noted to be affected. Given the previous EDS showing an effect on both motor and sensory fibers, the clinical significance of these recent EDS is unclear. In addition, the patient is not noted to have undergone recommended conservative management as defined by ACOEM. Therefore, ulnar nerve transposition at the left elbow is not medically necessary. In addition, the patient had undergone a previous ulnar release at the elbow and wrist.

EMG/NCV of the left elbow: Overturned

Claims Administrator guideline: Decision based on MTUS Elbow Complaints 2007.

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

Decision rationale: The patient is a 54 year old with signs and symptoms of a possible recurrent left elbow entrapment neuropathy. The patient had previously undergone release of the ulnar nerve at the elbow and the wrist on 8/26/14. The patient had undergone electrodiagnostic studies dated 10/27/15 noting normal nerve conduction velocities of the ulnar nerve but ongoing denervation in the ADM and FDI muscles suggesting an ulnar neuropathy. The patient was noted on examination to have subluxation of the ulnar nerve at the elbow and to have 1st dorsal muscle atrophy. Previous electrodiagnostic study from June 23, 2014 noted left ulnar neuropathy affecting both the ulnar sensory and motor fibers. Given the previous EDS, which showed involvement of motor and sensory fibers, it is prudent to repeat EMG studies to evaluate the affect on the muscles supplied by the ulnar nerve. Therefore, EMG/NCV of the left elbow is medically necessary. Given the previous EDS, this should satisfy the concern of the UR.