

<b>Case Number:</b>	CM15-0030564		
<b>Date Assigned:</b>	02/25/2015	<b>Date of Injury:</b>	02/26/2010
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	02/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/18/2015

### 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 34 year old female, who sustained an industrial injury on 2/26/10. She has reported pain in the bilateral arms and hands. The diagnoses have included carpal tunnel syndrome, lesion of ulnar nerve and bilateral cubital tunnel release. Treatment to date has included EMG/NCV studies, ice/heat and oral medications. As of the PR2 dated 1/13/15, the injured worker reports numbness and tingling in both hands. The treating physician noted a positive Tinel's test at the ulnar nerve on both elbow and wrists. The treating physician requested a left elbow ulnar nerve decompression with submuscular transposition, post-op occupational therapy 3x week x 4 weeks, pre-op clearance (CBC/PT/PTT/INR/Chem 7/UA/ chest x-ray/EKG/H&P) and Norco 10/325mg #30. On 2/6/15 Utilization Review non-certified a request for a left elbow ulnar nerve decompression with submuscular transposition, post-op occupational therapy 3x week x 4 weeks, pre-op clearance (CBC/PT/PTT/INR/Chem 7/UA/ chest x-ray/EKG/H&P) and Norco 10/325mg #30. The utilization review physician cited the ACOEM guidelines for elbow disorders. On 2/12/15, the injured worker submitted an application for IMR for review of a left elbow ulnar nerve decompression with submuscular transposition, post-op occupational therapy 3x week x 4 weeks, pre-op clearance (CBC/PT/PTT/INR/Chem 7/UA/ chest x-ray/EKG/H&P) and Norco 10/325mg #30. The patient is noted to have undergone previous left ulnar nerve decompression and left endoscopic carpal tunnel release and forearm fasciotomy on 2/26/12. Previous electrodiagnostic studies from 10/24/14 are stated to show mild cubital syndrome bilaterally. Conservative management documented included rest, ice, medical management and activity/work modification. Documentation from 9/8/14 notes that the patient's

paresthesias and function is worsening despite conservative management. The specific conservative management was not detailed.

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

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

**Left elbow ulnar nerve decompression with submuscular transposition:** 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) Page(s): 37.

**Decision rationale:** The patient is a 34-year-old female with signs and symptoms of probable recurrent left cubital tunnel syndrome that is affecting her function. Electrodiagnostic studies confirm a mild entrapment neuropathy of the ulnar nerve. The patient has undergone some conservative management. However, there has been no specific mention of the use of elbow pads, removing opportunities to rest the elbow on the ulnar groove, use of elbow pads and avoiding prolonged elbow flexion while sleeping, as recommended from below. There was no documentation of muscle wasting to suggest a severe condition. In addition, submuscular transposition is specifically not recommended and there was not sufficient documentation to justify its use. Therefore, left elbow ulnar nerve decompression with submuscular transposition should not be considered medically necessary. 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. Simple Decompression Quality studies<sup>118, 119, 121, 122</sup> 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<sup>121, 122</sup> 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].

**Post-op 12 sessions of Occupational therapy (3x 4 weeks): Upheld**

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

**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.

**Pre-Op clearance: CBC/PT/PTT/INR/Chem 7/UA/CXR/EKG/H&P: Upheld**

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

**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.

**Post-op Medication: Norco 10/325mg #30: Upheld**

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

**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.