

Case Number:	CM15-0053484		
Date Assigned:	03/26/2015	Date of Injury:	03/02/2014
Decision Date:	05/05/2015	UR Denial Date:	02/25/2015
Priority:	Standard	Application Received:	03/20/2015

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 27 year old female, who sustained an industrial injury on 03/02/2014. She reported severe pain in both elbows and wrists. The injured worker was diagnosed as having sprain/strain elbow both and sprain/strain wrist/hand unspecified both. Treatment to date has included x-rays, physical therapy, acupuncture, medications, splinting and electrodiagnostic studies. According to a progress report dated 02/03/2015, the injured worker complained of pain in the medial aspect of her left elbow with some popping. She had intermittent numbness in the left ring and small fingers. Physical examination revealed slight tenderness over the ulnar nerve at the elbow. The ulnar nerve subluxes at the left medial epicondyle with some pain and popping. Tinel's sign and elbow flexion tests were positive at the left cubital tunnel. There was mild radial tunnel tenderness on the left. There was full range of motion without instability at the elbows. Diagnoses included chronic left ulnar nerve subluxation at the elbow with secondary cubital tunnel symptoms, status post left radial head fracture, status post right radial neck fracture and status post right wrist sprain. The provider noted that her electrodiagnostic studies were negative and was not unusual as this was a dynamic condition and not a static compression. Recommendations included left cubital tunnel release with anterior transposition of the ulnar nerve.

IMR ISSUES, DECISIONS AND RATIONALES

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

One left cubital tunnel release with anterior transposition of the ulnar nerve: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 37. Decision based on Non-MTUS Citation Book Chapter Compression Neuropathies Susan E. Mackinnon and Christine B. Novak Green's Operative Hand Surgery, chapter 30, 977-1014.

Decision rationale: The patient is a 27 year old female with a history of a left elbow fracture. She is noted to have signs and symptoms of left cubital tunnel syndrome with subluxation of the ulnar nerve. Electrodiagnostic studies did not confirm the diagnosis. Conservative management has included splinting, ulnar nerve precautions, physical therapy, medical management and activity modification. The requesting surgeon notes that there is a false negative rate with electrodiagnostic studies and that the patient's condition is a dynamic condition. From Chapter 10, page 37. 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. 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. From Green's Operative Hand Surgery: 'Compression of the ulnar nerve at the cubital tunnel is extremely common and second in incidence only to carpal tunnel syndrome. The diagnosis is a clinical one because electrodiagnostic testing is frequently negative.' Based on the overall clinical picture, the patient has a clear clinical diagnosis of left cubital tunnel syndrome that has failed an exhaustive regimen of conservative management over many months. As stated by the requesting surgeon and confirmed by Green's Operative Hand Surgery, electrodiagnostic studies can be negative in certain patients. In addition, this patient has clinical evidence that she may benefit from anterior transposition of the ulnar nerve. Therefore, surgical treatment of cubital tunnel with anterior transposition of the ulnar nerve should be considered medically necessary.