

<b>Case Number:</b>	CM15-0082025		
<b>Date Assigned:</b>	05/05/2015	<b>Date of Injury:</b>	05/18/2011
<b>Decision Date:</b>	06/03/2015	<b>UR Denial Date:</b>	04/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2015

### 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: California, Indiana, Oregon  
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:

The injured worker is a 49 year old male, who sustained an industrial injury on 05/18/2011. He reported injuries to his cervical and lumbar spine, right shoulder, right elbow, right hip, right knee, and right hand. The injured worker is currently diagnosed as having trochanteric bursitis status post injection with improvement, iliotibial band tendinitis, and hip joint inflammation. Treatment and diagnostics to date has included left knee MRI, lumbar spine x-rays, right shoulder surgery, right elbow surgery, epidural injections, physical therapy, and medications. In a progress note dated 02/25/2015, the injured worker presented with complaints of low back and right hip pain. The treating physician reported requesting authorization for right ulnar nerve surgery and associated surgical services.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right ulnar nerve anterior transposition:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 31, 44.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 18.

**Decision rationale:** CA MTUS/ACOEM Elbow Complaints Chapter 10 (2007 supplement) page 18 states that focused NCS/EMG with "inching technique" is required for the accurate diagnosis of cubital tunnel syndrome. There is no evidence of cubital tunnel syndrome on the EMG from 7/16/14. The request is not medically necessary.

**Pre-operative labs and EKG:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 18.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Twelve sessions of post-operative hand therapy:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 18.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.