

Case Number:	CM15-0087406		
Date Assigned:	05/11/2015	Date of Injury:	09/06/2009
Decision Date:	06/24/2015	UR Denial Date:	04/16/2015
Priority:	Standard	Application Received:	05/06/2015

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: Arizona

Certification(s)/Specialty: 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, with a reported date of injury of 09/06/2009. The diagnoses include left elbow lateral epicondylitis and left elbow ulnar neuropathy. Treatments to date have included electrodiagnostic studies of the left upper extremity on 02/25/2013; and oral medications. The progress report dated 04/02/2015 indicates that the injured worker complained of constant left elbow pain with numbness down to the hand. The range of motion was reduced and the movement as painful. The objective findings include tenderness to palpation over the medial epicondyle, and pain with range of motion. The treating physician requested left elbow ulnar nerve decompression with possible anterior transposition surgery. The treatment plan indicated that the left elbow surgery was previously authorized per the recommendation of the agreed medical examination in mid-2013. The injured worker declined surgery at that time and continued working. He was released from care and considered maximum medically improved in mid-2014 by the agreed medical examination and future medical care provisions were outlined.

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 possible anterior transposition surgery:

Overtuned

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): 37.

Decision rationale: 54-year-old male with a date of injury of 09/06/2009 and diagnosis of left elbow lateral epicondylitis and left elbow ulnar neuropathy. EMG study 2/25/2013 reveals findings consistent with left ulnar neuropathy and mild carpal tunnel syndrome. Examination findings are not well documented in the chart. Exam 3/31/2015 reveals findings of decreased sensation in a radial nerve distribution left upper extremity, which I believe, may have been documented in error. Exam 4/2/2015 documents tenderness to palpation at the medial left epicondyle and pain with range of motion as well as numbness to the hand, although the nerve distribution on examination is lacking. 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. There is a high possibility that the surgery will not relieve symptoms. The worker declined ulnar nerve surgery in 2013 and continued working. He was released from care and considered maximum medically improved in mid-2014. However, since that time his symptoms have appeared to progress and become more problematic. In well defined but infrequent cases 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. Conservative therapy (avoiding pressure on the nerve, activity modification, physical therapy with nerve gliding exercises and if warranted, splinting at the elbow) seems to have best results when patients present with minimal symptoms. When atrophy is present or paresthesias are persistent, non-operative management seems to provide the lowest rate of relief and the highest rate of recurrence. (Hand (NY). 2009 Dec; 4(4): 350-356) Unfortunately, there is a paucity of information based on prospective randomized clinical studies comparing the different surgical methods. It appears that this patient has been medically and conservatively managed with progression of his symptoms over time. He needs to be educated fully regarding the success (or lack of success) in chronic ulnar neuropathy treated surgically. As long as he understands these risks, I think that it is reasonable to proceed with the surgery requested as was approved initially in 2013. The request is medically necessary.