

<b>Case Number:</b>	CM14-0119060		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	04/27/2012
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	07/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/29/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Alabama. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 57 year old male who sustained an injury 04/27/2012 while he was picking up a heavy box. Diagnostic studies reviewed include EMG/NCV dated 01/13/2014 revealed evidence for a left median sensorimotor mononeuropathy at the wrist and right median sensory mononeuropathy at the wrist. An MRI of the right elbow without contrast dated 02/10/2014 revealed increased arthrosis at the ulnotrochlear and radiocapitellar articulation with marked osseous spurring seen along the coronoid; thickening and scarring of the medial collateral ligament. There is partial stripping of the distal medial collateral ligament anterior bundle at the insertion; and mild increased signal of the ulnar nerve in the cubital tunnel with scarring of the acrcuate ligament and medial collateral ligament at the floor of the cubital tunnel. A visit note dated 03/24/2014 states the patient presented with complaints of right elbow pain without radiation. He rated his pain as 7/10 at its worst. The patient reported the pain has affected his quality of life. He was noted to be taking Trazodone for pain which has been helpful. Objective findings on exam revealed range of motion elbow with flexion on the left at 120 degrees and on the right at 130 degrees; extension on the left at +5 degrees and extension on the right at 0 degrees. On a note dated 06/06/2014, the patient presented with no change in symptoms. Previously, the patient reported no radiation, now the pain radiates throughout the right arm. He describes it as aching, dull, stinging, and throbbing. The pain becomes exacerbated by lifting, pulling, reaching and carrying. On exam, elbow flexion is to 140 on the right and extension on the right is 20 degrees. Forearms demonstrated supination at 70 degrees bilaterally. Strength is decreased at 4+/5 in flexion and extension. The patient is diagnosed with lateral epicondylitis and olecranon bursitis. The patient has been recommended for a surgical release of adhesions and decompression of the cubital tunnel.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Right cubital tunnel release:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow, Surgery for Cubital Tunnel Syndrome

**Decision rationale:** The ODG for cubital tunnel syndrome surgery states "ODG Indications for Surgery -- Surgery for cubital tunnel syndrome: Initial conservative treatment, requiring ALL of the following:- Exercise: Strengthening the elbow flexors/extensors isometrically and isotonicly within 0-45 degrees - Activity modification: Recommend decreasing activities of repetition that may exacerbate the patient's symptoms. Protect the ulnar nerve from prolonged elbow flexion during sleep, and protect the nerve during the day by avoiding direct pressure or trauma. - Medications: Nonsteroidal anti-inflammatory drugs (NSAIDs) in an attempt to decrease inflammation around the nerve. - Pad/splint: Use an elbow pad and/or night splinting for a 3-month trial period. Consider daytime immobilization for 3 weeks if symptoms do not improve with splinting. If the symptoms do improve, continue conservative treatment for at least 6 weeks beyond the resolution of symptoms to prevent recurrence." A note from 5/19/14 states "The patient has been treated with conservative care to date since that time by [REDACTED]." No specific exercises, activity modification, medications, or pad/splints were documented. A note from 7/9/14 states "He has tried Motrin, Advil, and Aleve over the counter which is not helpful..." which addresses the NSAID use. However, there is no documented history of exercise, activity modification, or pad/splint use. In addition, the signs/symptoms of cubital tunnel syndrome impinging on the ulnar nerve are not demonstrated in the provided documentation to support a diagnosis of cubital tunnel syndrome. Therefore, based on the above guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.