Case Number:	CM14-0142630		
Date Assigned:	09/10/2014	**Date of Injury:**	09/08/2011
Decision Date:	10/14/2014	**UR Denial Date:**	08/28/2014
Priority:	Standard	**Application Received:**	09/03/2014

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 Internal Medicine, has a subspecialty in Pulmonary Diseases and is licensed to practice in California. 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 injured worker is a 34-year-old female who reported an injury on 09/08/2011; while moving the last keg, she felt a pop in her left shoulder and neck, with pain shooting down her left arm. Diagnoses were status post left shoulder stabilization with inadequate postoperative rehabilitation, left ulnar neuropathy. Past treatment was medications, physical therapy, and a TENS unit. Diagnostic studies were EMG that revealed ulnar nerve impingement across the cubital tunnel and Guyon's canal between pisiform and hamate bones at the wrist. Surgical history was arthroscopic labral repair of the capsulorrhaphy. Physical examination on 08/06/2014 revealed complaints of numbness and tingling of the 4th and 5th fingers of the left hand, and some residual pain in the left shoulder. Medications were not reported. Examination revealed active range of motion of the left shoulder was to 160 degrees for flexion, 150 degrees extension, 130 degrees abduction, 40 degrees for adduction, 70 degrees external rotation, and 80 degrees internal rotation. There was a positive Tinel's at the left elbow. The injured worker had severe flexor carpi ulnaris atrophy on the left. Intrinsic strength to gross testing appeared to be normal with no gross evidence of intrinsic atrophy. Treatment plan was for left ulnar nerve transposition flexor/pronator lengthening. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left ulnar nerve transposition Flexor/Pronator lengthening: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 44-47.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 25-26.

Decision rationale: The request for Left ulnar nerve transposition Flexor/Pronator lengthening is not medically necessary. The California ACOEM states although it is possible to entrap a nerve at any point along its course, there are 2 main areas for entrapment of the ulnar nerve at the elbow. The first is in the condylar groove, and the second begins immediately distal to the elbow joint in the true, anatomic cubital tunnel. The guidelines recommend activity modification, recommended for acute, subacute, and chronic ulnar nerve entrapment. Avoidance of the leaning on the ulnar nerve at the elbow is recommended for the treatment of ulnar nerve entrapment. The avoidance of prolonged hyper flexion of the elbow is recommended for the treatment of ulnar nerve entrapment. Proper testing to localize the abnormality involves a nerve conduction study that includes at least stimulation above and below the elbow, is recommended for assessment of ulnar nerve entrapment. Most of the published literature does not distinguish between types of ulnar neuropathy despite the improbability that the risk factors and treatments are the same. This produces a substantial lack of clarify in the available evidence. Proper testing to localize the abnormality involves a nerve conduction study that includes at least stimulation above and below the elbow. Aside from surgical studies, there are no quality studies on which to rely for treatment of ulnar neuropathies, and there is no evidence of benefits of the following treatment options. However, these options are low cost and have few side effects, and are not invasive. Recommended treatment is elbow padding, avoidance of leaning on the ulnar nerve at the elbow, avoidance of prolonged hyper flexion of the elbow, and although not particularly successful for a neuropathic pain, utilization of NSAIDs. Diagnostic studies revealed positive for ulnar nerve impingement. It was not reported that the injured worker had tried elbow padding, avoidance of leaning on the ulnar nerve, or avoidance of prolonged hyper flexion of the elbow. Conservative care modalities such as physical therapy, elbow padding and avoidance of prolonged hyper flexion of the elbow to avoid surgery are recommended. The clinical information submitted for review does not justify the certification for left ulnar nerve transposition flexor/pronator lengthening. Therefore, this request is not medically necessary.