

Case Number:	CM14-0180500		
Date Assigned:	11/05/2014	Date of Injury:	11/25/2013
Decision Date:	12/09/2014	UR Denial Date:	09/30/2014
Priority:	Standard	Application Received:	10/30/2014

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 Orthopaedic Surgery 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:

This 45-year-old female sustained an industrial injury on 11/25/13. Injury occurred when she was reaching up to get a box weighing approximately 25 pounds. She lost her grip and the box fell hitting her left hand and forearm, causing her arm to jerk downward. Records indicated that the patient attended 37 sessions of physical therapy from 5/8/14 to 9/10/14 for a diagnosis of carpal tunnel syndrome with minimal reduction in symptoms. Records documented 19 visits of physical therapy from 7/21/14 through 9/25/14 for a diagnosis of left hand, wrist, elbow, and shoulder sprain/strain. Use of a wrist brace was documented. The 7/7/14 left elbow MRI impression documented mild tendinitis of the extensor tendon and medial collateral ligament. There was fluid in the joint space and radiographs were suggested to exclude possibility of any fractures. The 7/16/14 EMG study revealed electrophysiological evidence of mild chronic denervation due to left ulnar neuropathy. The nerve conduction velocity study findings revealed mild left ulnar nerve entrapment at the elbow. The 8/15/14 treating physician progress report cited left elbow pain aggravated by gripping and grasping, with numbness in the 4th and 5th digits. Left elbow physical exam documented positive Tinel's, lateral epicondyle tenderness. Left elbow range of motion was limited with flexion 120, pronation 65, and supination 65 degrees. The diagnosis included left hand sprain/strain, rule-out tendinitis and carpal tunnel syndrome, left wrist sprain/strain, rule-out internal derangement and triangular fibrocartilage complex tear, left flexor extensor carpi ulnaris tendinitis, rule-out partial tear, left elbow sprain/strain, left cubital tunnel syndrome, and left shoulder sprain/strain, tendinitis and impingement. Medications included Norco, Ultram, Prilosec, and Fexmid. The treatment plan requested left ulnar nerve transposition, left shoulder corticosteroid injection, paraffin wax for home use, and physical therapy 2-3 times per week for 6 weeks. The 9/26/14 treating physician progress report was unchanged from the 8/15/14 progress report. The treatment plan requested authorization of a left

cubital tunnel release with ulnar nerve transposition and medial epicondylectomy. The 9/30/14 utilization review denied the request for left ulnar nerve transposition as there was no documentation that the patient had utilized elbow padding or had been instructed to avoid leaning on the ulnar nerve at the elbow and prolonged elbow hyperflexion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Ulnar Nerve Transposition: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 36-37.

Decision rationale: The California MTUS guidelines state that 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. Absent findings of severe neuropathy such as muscle wasting, at least 3-6 months of conservative care should precede a decision to operate. Guideline criteria have not been met. There is no evidence of severe neuropathy, such as muscle wasting. There is no evidence of elbow splinting/padding or education regarding avoidance of ulnar nerve irritation. There is no evidence that physical therapy has specifically addressed cubital tunnel syndrome. The available records documented extensive physical therapy to the left upper extremity but evidence of 3 to 6 months of a comprehensive guideline-recommended non-operative treatment protocol trial for a diagnosis of cubital tunnel syndrome and failure has not been submitted. Therefore, this request is not medically necessary.