

<b>Case Number:</b>	CM14-0181510		
<b>Date Assigned:</b>	11/06/2014	<b>Date of Injury:</b>	07/24/2013
<b>Decision Date:</b>	12/09/2014	<b>UR Denial Date:</b>	10/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2014

### 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 Plastic and Reconstructive Surgery and is licensed to practice in Maryland, Virginia and North Carolina. 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 54 year old male with a reported date of injury on 7/24/13 who requested left cubital tunnel release. Primary treating physician report dated 10/7/14 notes a request for a left cubital tunnel release had been submitted. The patient continues with activity modification and pain of the left elbow with paresthesias of the left 4th and 5th digits fingers. There is tenderness on palpation of the medial epicondylar area in the cubital tunnel area in the left. There is continued decreased light touch sensation of the left 4th and 5th digits. Progress report dated 10/1/14 notes pending surgical authorization for a left lateral retinacular epicondylar release. A previous MRI report from 9/26/13 is stated to show significant lateral epicondylitis of the left elbow. He had previously undergone left shoulder surgery on 4/5/14. The patient complains of pain in the cervical spine, left shoulder, left elbow and hand. He had previously undergone 2 cortisone injections, complicated by an adverse reaction requiring a hospital visit. Diagnoses include sprain/strain of the cervical spine, status post left shoulder surgery, left elbow lateral epicondylitis and sprain/strain of the left hand. 'I am requesting authorization for left epicondylar release.' Conservative management has included physical therapy, local injections, rest, and activity modification. In addition, DME and 24 postoperative physical therapy visits are requested. Electrodiagnostic studies of the bilateral upper extremities are requested to evaluate for radiculopathy of the left upper extremity. Pain medication is switched from Norco to Ultram. Progress report dated 9/16/14 notes continued pain of the left lateral epicondylar area of the elbow. He reports intermittent cramping of the 4th and 5th digits of the left hand. Tennis elbow testing remains positive and there is tenderness of the left elbow lateral epicondylar area. Recommendation is to continue with a home exercise program. Progress report dated 9/3/14 notes pending surgical authorization for a left lateral retinacular epicondylar release. Complaints include pain of the cervical spine and left elbow and numbness in the left hand. Previous

medical reviews are documented, which included diagnosis of left elbow lateral epicondylitis and conservative treatment including activity modification, cortisone injection, an elbow sleeve, medical management and physical therapy. Progress report dated 8/20/14 notes continued pain of the left lateral epicondylar area of the elbow. He denies paresthesias of the left upper extremity. Tennis elbow testing remains positive and there is tenderness of the left elbow lateral epicondylar area. There is no sensory deficit of the left upper extremity. Recommendation is to continue with medication and activity restriction. Primary treating physician report dated 8/14/14 notes pain of the left shoulder joint, neck and elbow that is getting better. Examination notes left elbow joint lateral epicondylar region with localized tenderness and swelling. There is good range of motion. Diagnoses include medial and lateral epicondylitis among other diagnoses. Local cream and a home exercise program are recommended. Primary treating physician report dated 7/3/14 notes pain of the left shoulder joint that is improving and left elbow pain. Examination notes left elbow joint lateral epicondylar region with localized tenderness and swelling. There is good range of motion. Diagnoses include medial and lateral epicondylitis among other diagnoses. Terocin patch to the left elbow, medication as needed, exercise and rehab program are recommended. Initial evaluation report dated 7/30/14 notes complaints of headaches, pain of the cervical spine with numbness of the left upper extremity, pain of the left shoulder, pain of the left elbow, and pain of the left hand. There is weakness, tingling and numbness of the left hand. His complaints affect his activities of daily living. Examination of the left elbow notes tenderness of the medial and lateral epicondyle and radial head. Grip strength is decreased on the left side. Tinel's is positive on the left side at the cubital tunnel as well as a positive compression sign. Diagnoses include sprain/strain of the cervical spine, status post left shoulder surgery, left elbow lateral epicondylitis and sprain/strain of the left hand. Plan was to request authorization for left lateral retinacular release epicondylar release, postoperative physical therapy and durable medical equipment. The patient had already had physical therapy and a cortisone injection that had sent him to the hospital. Previous recent progress reports note continued pain and tenderness of the left elbow lateral epicondylar region without paresthesias of the left upper extremity. UR review dated 10/16/14 did not certify left cubital tunnel release. Reasoning given was that 'There is no documentation of significant activity limitation, delayed NCV, failure of additional conservative treatment and a surgical report recommending left cubital tunnel release.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Left cubital tunnel release:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines/Cubital tunnel syndrome

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

**Decision rationale:** The patient is a 54 year old male with chronic left elbow pain mainly attributed to left elbow lateral epicondylitis. This is supported by MRI evaluation. This has

failed conservative management of physical therapy, cortisone injection, medical management, and activity restriction. It is documented to have affected his activities of daily living. However, the request for review is related to left cubital tunnel release. There are some signs and symptoms consistent with left cubital tunnel syndrome (ulnar nerve entrapment at the elbow); however, this diagnosis is not as clearly defined. The most recent evaluations note sensory disturbances in the ulnar nerve distribution of the left upper extremity, as well as positive Tinel's and compression test at the elbow. Recommendation is made for bilateral upper extremity electrodiagnostic studies to evaluate for a radiculopathy on the left side (not specifically ulnar nerve entrapment). ACOEM addresses indications for surgical treatment of ulnar nerve entrapment at the elbow. There must be adequate documentation of '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.' This has not been adequately documented in the medical records provided for review. In addition, a firm diagnosis on the basis of clear clinical evidence and positive electrical studies that correlate with clinical findings are necessary. Electrodiagnostic studies to evaluate for ulnar nerve entrapment have not been performed; but have been requested. Thus, based on the lack of required specific conservative management and confirmatory electrodiagnostic studies, left cubital tunnel release should not be considered medically necessary. From ACOEM, Chapter 10, Elbow complaints page 37: 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. Before proceeding with surgery, patients must be apprised of all possible complications, including wound infections, anesthetic complications, nerve damage, and the high possibility that surgery will not relieve symptoms. Absent findings of severe neuropathy such as muscle wasting, at least 3-6 months of conservative care should precede a decision to operate. Therefore, the request is not medically necessary.