

Case Number:	CM14-0097322		
Date Assigned:	09/16/2014	Date of Injury:	02/01/2010
Decision Date:	10/15/2014	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	06/25/2014

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 Texas. 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 68-year-old male airline technician who sustained an industrial injury on 2/1/10. The injured worker reported an onset of left elbow pain and discomfort while installing a fuel nozzle on a 737 engine. He was diagnosed with a rupture of the distal biceps tendon and underwent surgical repair. Past medical history was positive for diabetes mellitus, hyperlipidemia, hypertension, and anxiety. The injured worker presented on 12/18/13 with a flare-up of severe left elbow pain and numbness in the 4th and 5th fingers. The worker was last seen on 1/23/12. Physical exam documented pain with deep palpation of the biceps tendon near the bicipital tuberosity. There was full left elbow range of motion. The ulnar nerve was palpable with no inflammation and did not sublux over the medial epicondyle. Compression of the ulnar nerve did not trigger dysesthesias. There was very slight atrophy of the first dorsal interosseous but strength was 5/5. The treatment plan recommended ibuprofen and a magnetic resonance imaging scan to assess the biceps repair. The 2/12/14 left elbow magnetic resonance imaging scan impression documented tendinosis of the distal 15-20 mm of the distal biceps at its insertion, with no evidence of full thickness tear or bursitis. The 3/19/14 electrodiagnostic report documented evidence of mild left elbow ulnar motor neuropathy at the cubital tunnel region. The 4/1/14 treating physician report cited tenderness of the biceps tendon in the cubital fossa and positive Tinel's test in the cubital tunnel. There was decreased sensation over the ulnar nerve in the 4th and 5th fingers. Grip strength was decreased to 40 pounds left, compared to 110 right. Use of the left hand was quite limited and he was having a hard time doing his job. The treatment plan recommended left ulnar nerve transposition with exploration of the biceps tendon. The 6/9/14 treating physician report cited worsening of left 4th and 5th finger numbness. Numbness was brought on by repetitive activities and aggravated by elbow flexion. There was complaint of grip weakness and finger stiffness. Tinel's was positive at the left cubital tunnel. There was no

intrinsic atrophy. Sensation was intact to light touch over all upper extremity nerve distributions. There was 5/5 motor strength over all upper extremity nerve distributions. Electromyograph findings were suggestive of moderate ulnar nerve compression at the elbow. The treatment plan recommended left cubital tunnel release. The 6/17/14 utilization review denied the request for left ulnar nerve decompression as the worker had no physical signs of muscle denervation and the electrodiagnostic study showed evidence of conduction abnormality but no denervation in the ulnar innervated muscles. Guideline-recommended conservative treatment was not documented for 3 months or more.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Ulnar Nerve Decompression: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Work Loss Data Institute On-line Official Disability Guidelines (ODG) Treatment in Worker's Comp. Integrated Treatment/Disability Duration Guidelines. Elbow (Acute & Chronic). Surgery for cubital tunnel syndrome

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

Decision rationale: The Chronic Pain Medical Treatment 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 injured worker has failed conservative care. Absent findings of severe neuropathy such as muscle wasting, at least 36 months of conservative care should precede a decision to operate. Guidelines criteria have been met. This injured worker presents with worsening subjective complaints consistent with clinical and imaging findings of cubital tunnel syndrome. Reasonable conservative treatment has been tried over the past 6 months and has failed to produce sustained benefit. Significant impairment in work ability is documented. Injured worker has completed 6 months of reasonable conservative care with no sustained benefit. There is clinical and electrodiagnostic evidence of cubital tunnel syndrome. Therefore, this request is medically necessary.