

Case Number:	CM14-0097568		
Date Assigned:	07/25/2014	Date of Injury:	01/14/2011
Decision Date:	10/20/2014	UR Denial Date:	05/29/2014
Priority:	Standard	Application Received:	06/16/2014

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 Orthopedic 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 50-year-old male drywall installer sustained an industrial injury on 1/14/11 relative to repetitive work duties. Past surgical history was positive for right shoulder arthroscopic surgery in April 2012 and a second surgery on 12/5/12 to remove anchors and repair the rotator cuff. The patient underwent left shoulder subacromial decompression on 6/13/13. The patient reported decreased right elbow range of motion following the first shoulder surgery and the prolonged use of a sling. A corticosteroid injection had provided pain relief but had not improved range of motion. The 1/23/14 right elbow CT scan impression documented moderate osteoarthritis with a 3 mm osseous intra-articular body in the olecranon bursa. The 2/25/14 consulting physician report cited on-going right elbow pain with feeling of locking up. The patient reported about 7 weeks of decreased pain after the corticosteroid injection, but no improvement in range of motion. Physical exam documented range of motion 30-95 degrees with full pronation and supination. CT scan findings showed increased ulnar humeral arthritis and osteophytes filling of the olecranon fossa. There was a loose body in the posterior ulnar humeral joint. The remainder of the elbow surgery consult report was not available in the records provided. A request for right elbow arthroscopy with loose body removal, ulnar nerve decompression with transposition, and capsulectomy was submitted. The 5/29/14 utilization review modified the surgical request and denied the request for right elbow ulnar nerve decompression with transposition as records indicated the ulnar nerve did not quite sublux anterior to the medial epicondyle and there was no confirmatory EMG studies documenting ulnar neuropathy. The request for right elbow arthroscopy with loose body removal and capsulectomy was approved.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Elbow Ulnar Nerve Decompression with Transposition: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 40-43.

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 in the records of any electrodiagnostic studies establishing ulnar neuropathy. There are no clear clinical exam findings in the records suggestive of ulnar nerve entrapment. There is no evidence of significant activity limitations due to nerve entrapment; there is significant limitation due to loss of range of motion. Evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial specifically directed to the ulnar nerve and failure has not been submitted. Therefore, this request is not medically necessary.