

Case Number:	CM15-0110931		
Date Assigned:	06/17/2015	Date of Injury:	10/23/2000
Decision Date:	07/16/2015	UR Denial Date:	05/19/2015
Priority:	Standard	Application Received:	06/09/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Indiana, Oregon
 Certification(s)/Specialty: Orthopedic Surgery

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 51 year old male who reported an industrial injury on 10/23/2000. His diagnoses, and/or impressions, are noted to include: lesion of ulnar nerve; severe left ulnar sensory neuropathy; bilateral upper extremity radiculopathy with severe bilateral cubital tunnel syndrome, right carpal tunnel, and status-post right carpal/cubital tunnel release in 2014; along with major depression, narcotic dependency, panic disorder, and migraine headaches. No current imaging studies are noted. His treatments have included diagnostic studies; right ulnar nerve decompression and medial epicondylectomy on 4/1/2014; left elbow splint; psychiatric evaluation; occupational therapy (1/2015); medication management and rest from work as he is permanently disabled. The progress notes of 5/4/2015 reported tenderness and persistent sharp burning pain in the left elbow that radiated into his left forearm/wrist that was associated with numbness into the small finger. Objective findings were noted to include that he had failed significant conservative treatments and that the condition was worsening; the orthopedic recommendation for left ulnar nerve decompression at the elbow with epicondylectomy; obvious discomfort; the use of a single prong cane; demonstration of severe ulnar cubital tunnel Tinel's and positive left ulnar compression test with early claw deformity; the impression of no other options; and the injured workers desire to proceed with the recommended surgery. The physician's requests for treatments were noted to include the recommended left ulnar nerve decompression with medial epicondylectomy surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left ulnar nerve decompression at the elbow & medial epicondylectomy: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 37-38. Decision based on Non-MTUS Citation Official Disability Guidelines, Elbow Chapter (Online Version): Surgery for cubital tunnel syndrome (ulnar nerve entrapment) (2015) Official Disability Guidelines: Elbow Chapter (Online Version): Surgery for epicondylitis (2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) elbow and Other Medical Treatment Guidelines Kim, Kang Wook, et al. "Minimal epicondylectomy improves neurologic deficits in moderate to severe cubital tunnel syndrome." *Clinical Orthopaedics and Related Research* 470.5 (2012): 1405-1413.

Decision rationale: CA MTUS/ACOEM is silent on the issue of surgery for cubital tunnel syndrome. According to the ODG, Elbow section, Surgery for cubital tunnel syndrome, indications include exercise, activity modification, medications and elbow pad and or night splint for a 3-month trial period. Simple transposition is recommended unless instability is documented. Epicondylectomy for cubital tunnel is not addressed by ODG. Current research is referenced above. In this case, there is clear evidence of cubital tunnel syndrome on the EMG as well as documentation of appropriate non-surgical care for 3 months including hand therapy and night splinting. The request is medically necessary and appropriate.