

Case Number:	CM15-0063277		
Date Assigned:	04/09/2015	Date of Injury:	07/10/2008
Decision Date:	05/20/2015	UR Denial Date:	03/26/2015
Priority:	Standard	Application Received:	04/02/2015

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: Minnesota, Florida
 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 60 year old male with an industrial injury dated July 10, 2008. The injured worker diagnoses include history of traumatic right hand industrial injury in 2008, severe cervical spondylosis, bilateral epicondylitis, past narcotic dependency detox, gastritis, reports of insomnia, smoker, adjustment disorder due to chronic pain and depressed mood, right cubital tunnel syndrome. He has been treated with diagnostic studies, prescribed medications and periodic follow up visits. According to the progress note dated 12/04/2014, the injured worker reported severe right forearm pain. Objective findings revealed severe tenderness to right lateral epicondyle and pain with extension of the wrist. Documentation noted positive Tinel's sign at medial epicondyle and over right cubital tunnel with hypoesthesia in the right ulnar nerve distribution. Allodynia in the right fifth amputation stump with hyperalgesia in the right upper extremity were also noted on examination. In a progress note dated 2/12/2015, the treating physician noted that the Magnetic Resonance Imaging (MRI) revealed a strong presentation of an osteochondral defect. Physical exam revealed tenderness in the lateral and medial epicondyle and cubital tunnel with cubital tunnel syndrome that was positive with Tinel's sign. The treating physician prescribed services for right elbow arthroscopic, debridement lateral epicondyle, ulnar nerve transposition now under review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right elbow arthroscopic, debridement lateral epicondyle, ulnar nerve transposition:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 18, 19, 35, 37.

Decision rationale: The injured worker is a 56-year-old male with a date of injury of July 10, 2008. Per qualified medical evaluation of January 31, 2011 the assessment was traumatic amputation of distal phalanx, right little finger with neuroma formation, distal phalangeal fracture, right ring finger with tendon injury and arthrosis of DIP joint and PIP joint, and cubital tunnel syndrome, right elbow. The primary treating physician's supplemental report dated May 30, 2014 indicates ongoing right upper extremity pain with use of narcotics. On 6/10/2014 the assessment was right fifth finger neuroma. The plan was excision of the neuroma of the right fifth finger. An MRI scan of the right elbow dated January 14, 2015 is noted. The impression was 1. There is mild amount of fluid seen within the elbow joint but no osteochondral defect, trabecular fracture or areas of suspicion for epicondylar lesions present. 2. There is a subchondral focal area of bone marrow edema seen at the capitellum measuring 0.4 cm but no cartilaginous abnormalities or osteochondral defects seen. An orthopedic consultation report of December 8, 2014 revealed complaints of dull to sharp pain in the elbow, radiating pain intermittently to the wrist and upper arm and to the right fourth and fifth fingers. Authorization was requested for an MRI of the right elbow, EMG nerve conduction studies of the upper extremities and ultrasound study of the right elbow. He was fitted with a tennis elbow brace and a Futuro wrist brace. A request for right elbow arthroscopic debridement lateral epicondyles, ulnar nerve transposition was not and certified by utilization review, as there was no EMG/nerve conduction study documented. With regard to the cubital tunnel release and request for ulnar nerve transposition, California MTUS guidelines indicate 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 for 3-6 months including full compliance in therapy, use of elbow pads, removing opportunities to rest the elbow on the ulnar groove, work station changes if applicable, and avoiding nerve irritation at night by preventing prolonged elbow flexion while sleeping. The documentation provided does not indicate electrodiagnostic studies were done. There is no documentation of the required 3-6 months of conservative treatment with full compliance as noted above. Therefore the request for anterior transposition of the ulnar nerve is not supported. With regard to lateral epicondylalgia, and the MRI scan did not show a definite osteochondral defect and as such arthroscopy is not indicated. The guidelines recommend conservative care for a minimum of 3-6 months for lateral epicondylalgia. In light of the above, arthroscopy is not indicated. As such, the request for arthroscopy of the right elbow and ulnar nerve transposition is not supported by evidence-based guidelines and the medical necessity of the request has not been substantiated. The request is not medically necessary.