

<b>Case Number:</b>	CM14-0113891		
<b>Date Assigned:</b>	08/04/2014	<b>Date of Injury:</b>	08/23/2013
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	06/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2014

### 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 52-year-old male sustained an industrial injury on 8/23/13. Injury occurred while cutting metal with a power grinder. The grinder hit concrete and snapped back with the blade hitting his wrist. The patient sustained a complicated open wound of the wrist including open fracture of the triquetrum requiring irrigation and debridement. He underwent repair of the ulnar nerve, ulnar artery, and flexor profundus tendon of the little finger, repair of the partial laceration to the digitorum profundus tendon of the ring finger, and repair of the partial laceration to the flexor digitorum superficialis tendon of the small finger. The 3/25/14 nerve conduction study showed evidence of severe left sensory and motor ulnar neuropathy/axonopathy. There was some decrease in conduction velocity across the elbow with possible concomitant left ulnar neuropathy across the elbow. There was left median neuropathy at the wrist (carpal tunnel syndrome). The 4/10/14 treating physician report cited continued lack of sensation and constant tingling in the fingertips of the left hand and weakness. There was increased numbness in the left middle finger. Left wrist/hand exam findings documented limited wrist flexion/extension and significant improvement in flexion/extension of the digits. He was able to make a full fist and had near full extension. There was no evidence of clawing of the left small and ring fingers. He could abduct and adduct the thumb and digits, although this was significantly weak and there was thenar muscle atrophy. Tinel's was positive over the carpal and Guyon's tunnel. Phalen's and elbow flexion tests were positive. There was abnormal sensation and two-point discrimination to the left middle, ring and small fingers. Grip strength was decreased 50% on the right. The treating physician opined that the severity of findings could suggest severe scarring around the nerve. The treatment plan recommended re-exploration of the ulnar nerve, neurolysis with release of scar tissue around the ulnar nerve, and carpal tunnel release. The 5/20/14 PQME report documented concurrence with the recommendation for exploration and repair of the ulnar nerve

with a view to restoring functionality relative to significant sensory deficits. The 6/16/14 utilization review denied the request for post-operative occupational therapy as the surgery was not found to be medically necessary.

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

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

**Post Operative OT 3 times per week for 4 weeks:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 22.

**Decision rationale:** The California Post-Surgical Treatment Guidelines for ulnar nerve repair suggest a general course of 20 post-operative visits over 10 weeks during the 6-month post-surgical treatment period. Guideline criteria have been met. The treatment plan recommended re-exploration of the ulnar nerve, neurolysis with release of scar tissue around the ulnar nerve, and carpal tunnel release. This is the initial request for post-operative physical therapy and is consistent with guideline recommendations. Therefore, given the proposed surgery, this request for post-operative occupational therapy 3 times per week for 4 weeks is medically necessary.