

Case Number:	CM15-0166597		
Date Assigned:	09/04/2015	Date of Injury:	04/10/2009
Decision Date:	10/13/2015	UR Denial Date:	08/10/2015
Priority:	Standard	Application Received:	08/25/2015

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: Illinois, California, Texas
 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:

This injured worker is a 62-year-old female who sustained an industrial injury on 4/10/09, relative to cumulative trauma as a phlebotomist. Surgical history was positive for left shoulder arthroscopy, date and procedure not documented. Records documented that conservative treatment specific to the left wrist/hand had included 6 visits of acupuncture for carpal tunnel syndrome. The 1/15/15 initial treating physician report cited intermittent left sided neck pain radiating to the left arm to the hand, and weakness in the left hand and arm. Pain was aggravated by arm movement and affected by weather. Pain was relieved by medications. Upper extremity exam documented left elbow range of motion mildly limited with positive ulnar Phalen's test. The diagnosis included left cubital tunnel syndrome. The treatment plan recommended an upper extremity electrodiagnostic study. The 4/22/15 treating physician report stated that there was no change in the injured worker's subjective complaints or objective findings. She continued to have pain and symptoms in her cervical spine, lumbar spine, and left shoulder. The treatment plan recommended cervical and lumbar spine MRIs, and EMG/NCV studies of the left upper extremity. The 6/11/15 treating physician report stated that the injured worker's subjective complaints remained the same. Left upper extremity exam showed the hand had some purple discolorations, raising the question of Raynaud's phenomenon which was actually an issue that could explain why she had such significant symptomatology. Her neurologic deficit in the left upper extremity raised the question of peripheral entrapment versus cervical spine central avulsion. Neurodiagnostic comprehensive testing was recommended. The treatment plan indicated that topical compound creams had been dispensed and prescriptions given. The 7/16/15 treating physician report documented review of the 6/21/12 neurodiagnostic study that

showed the injured worker had cubital tunnel syndrome. The diagnosis included cervical spine pain, status post left shoulder surgery, and left wrist cubital tunnel syndrome. There was no documentation of physical findings. Nerve decompression surgery was recommended as this was a chronic problem and the longer it was delayed there was increasing risk of persistent nerve damage. Authorization was requested for nerve decompression of the left wrist and post op physical therapy twice a week for 4 weeks. The 8/10/15 utilization review non-certified the request for left wrist nerve decompression and associated post-op physical therapy as there was no documentation that the injured worker had exhausted conservative treatment and no physical exam findings supporting the diagnosis of cubital tunnel syndrome. The 8/11/15 left upper extremity electrodiagnostic study report cited pain at the neck, left shoulder, arm, elbow, lower back and left thigh associated with numbness and weakness. Symptoms were aggravated at night. Physical exam documented good upper extremity range of motion, no gross hand muscle atrophy, and good to normal strength. Upper extremity deep tendon reflexes were symmetrical and 2+ at the biceps and 1+ at the triceps. Phalen's test was negative bilaterally. Tinel's sign was positive at the left wrist and elbow. There was decreased light touch sensation over the left 5th finger. The impression documented entrapment neuropathy of the ulnar nerve across the left elbow with mild slowing of the nerve conduction velocity (cubital tunnel syndrome). There was no electrophysiological evidence of entrapment neuropathy of the left median or radial nerves, and no evidence to support left upper extremity motor radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nerve decompression left wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow, Surgery for cubital tunnel syndrome (ulnar nerve entrapment).

MAXIMUS guideline: Decision based on MTUS Elbow Complaints 2007, Section(s): Ulnar Nerve Entrapment.

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 fully met. This injured worker presents with left shoulder, arm and elbow pain. Symptoms were aggravated at night. There is clinical exam evidence of positive Tinel's at the elbow and decreased 5th finger sensation consistent with electrodiagnostic evidence of mild left cubital tunnel syndrome. There is no evidence of severe neuropathy such as muscle wasting. There was no functional assessment relative to the left elbow/wrist documented. Detailed evidence of at least 3 to 6 months of a recent comprehensive guideline-

recommended non- operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary at this time.

Post op physical therapy 2 times a week for 4 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.