

<b>Case Number:</b>	CM15-0190456		
<b>Date Assigned:</b>	10/02/2015	<b>Date of Injury:</b>	12/28/2012
<b>Decision Date:</b>	11/12/2015	<b>UR Denial Date:</b>	09/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/28/2015

### 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 33-year-old female who sustained an industrial injury on 12/28/12. Injury occurred when she tripped over some boxes and landed on both hands. Past medical history was positive for Erb's palsy involving the left upper extremity with some minor residuals. The 6/24/13 electrodiagnostic study evidenced bilateral carpal tunnel syndrome and mild right cubital tunnel syndrome. The injured worker underwent right carpal tunnel and cubital tunnel releases on 12/6/13. Records indicated that she had persistent numbness, tingling, and weakness in the left arm. The 6/22/15 bilateral upper extremity EMG/NCV documented electrodiagnostic evidence of mild to moderate bilateral median mononeuropathy at the base of the hand, and mild radial sensory mononeuropathy. There was no electrodiagnostic evidence for radial motor mononeuropathy or right or left mononeuropathy. The 9/8/15 treating physician report cited left arm symptoms including numbness, tingling and weakness. She reported an increased electrical like sensation that travels from her left elbow to the ring and small digits on her left hand. She reported left hand weakness. She had numbness and tingling in the 1st through 3rd digits. She had nighttime symptoms and had to shake her hand to wake it up. Symptoms were better with gabapentin. Physical exam documented full elbow, wrist, and hand/digit range of motion. Left hand exam documented positive Durkan's, positive Phalen's, and decreased sensation in digits 1 through 4. Left elbow exam documented positive Tinel's and elbow flexion test. Two point discrimination was decreased on the left. The EMG/NCV in June 2015 demonstrated mild to moderate bilateral carpal tunnel syndrome. The diagnosis was left ulnar neuropathy and left carpal tunnel syndrome. Authorization was requested for left endoscopic carpal tunnel release and ulnar nerve decompression, post-op hand therapy x 12 visits, and

pre-operative EKG and lab test. The 9/16/15 utilization review modified the request and certified the left endoscopic carpal tunnel release and pre-operative EKG and lab test. The request for post-op hand therapy x 12 visits was modified to 8 visits consistent with guidelines for carpal tunnel release. The request for left ulnar nerve decompression was non-certified as there was no electrodiagnostic evidence of left cubital tunnel syndrome and there was limited evidence that she had tried and failed all appropriate conservative measures for the left elbow.

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

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

#### **Left Ulnar Nerve Decompression: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

**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 met. This injured worker presents with left arm numbness and tingling in the 1st through 4th digits, an electrical sensation from her elbow to the 4th and 5th digits, and hand weakness. Symptoms wake her up at night and require shaking out. Clinical exam findings documented positive carpal tunnel and cubital tunnel provocative testing. However, electrodiagnostic evidence showed mild to moderate carpal tunnel syndrome and no evidence of ulnar neuropathy. Additionally, there was no detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial for cubital tunnel syndrome consistent with guidelines. Therefore, this request is not medically necessary at this time.

#### **Post-Op Hand Therapy x 12 Visits: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment 2009, Section(s): Carpal Tunnel Syndrome, Elbow & Upper Arm.

**Decision rationale:** The California MTUS Post-Surgical Treatment Guidelines for carpal tunnel release suggest a general course of 3 to 8 post-operative visits over 3-5 weeks during the 3-month post-surgical treatment period. For cubital tunnel release, guidelines support 20 visits over 10 weeks during the 6 month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. The 9/16/15 utilization review modified the request for 12 visits of post-op hand therapy to 8 visits consistent with guidelines for carpal tunnel release. There is no compelling reason submitted to support the medical necessity of care beyond guideline recommendations and the care already certified. As the surgical request for ulnar nerve decompression is not supported, this request is not medically necessary.