

<b>Case Number:</b>	CM15-0201354		
<b>Date Assigned:</b>	10/16/2015	<b>Date of Injury:</b>	03/11/2014
<b>Decision Date:</b>	11/25/2015	<b>UR Denial Date:</b>	10/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/13/2015

### 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: Maryland, Virginia, North Carolina  
 Certification(s)/Specialty: Plastic 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 37 year old male who sustained an industrial injury on March 11, 2015. The worker is being treated for: right worse than left lateral epicondylitis, status post one injection, right borderline cubital tunnel syndrome and left mild cubital tunnel, right mild carpal tunnel, status post two injections, and left carpal tunnel. Subjective: August 04, 2015, June 24, 2015 he notes "intermittent swelling in the hands and elbows," there is noted difficulty with "rolling bread, grasping, gripping, and driving." Symptoms have steadily progressed, bilateral "hand and elbow pain." Gastric upset from anti-inflammatory. Medications: June 24, 2015 anti-inflammatory agent. Diagnostic testing: electrodiagnostic evaluation bilateral upper extremities June 24, 2015. MRI request pending authorization. Treatment modalities: activity modifications, anti-inflammatory, injections, physical therapy, September 02, 2015 underwent left ulnar release, carpal tunnel release, and bilateral injections. On October 01, 2015 a request was made for right ulnar nerve release, right carpal tunnel release, and bilateral elbow injection which were noncertified by Utilization Review on October 07, 2015. Documentation from 8/24/15 note a positive response from Phalen's and carpal compression test which produce numbness and tingling. Electrodiagnostic studies from 6/24/15 note evidence of mild right carpal tunnel syndrome and borderline slowing of the ulnar nerve at the right elbow. The patient has been noted to have been using a wrist splint.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right ulnar nerve release:** Upheld

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

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

**Decision rationale:** The patient is a 37 year old male with signs and symptoms of possible ulnar nerve entrapment at the right elbow. Electrodiagnostic studies only support a borderline condition. The patient has failed some conservative management of steroid injection and medical management. However, additional conservative management is recommended as follows: From ACOEM, Chapter 10, page 18 and 19, the following is stated with respect to cubital tunnel syndrome: Aside from surgical studies, there are no quality studies on which to rely for treatment of ulnar neuropathies, and there is no evidence of benefits of the following treatment options. However, these options are low cost, have few side effects, and are not invasive. Thus, while there is insufficient evidence, these treatment options are recommended: Elbow padding [Insufficient Evidence (I), Recommended]; Avoidance of leaning on the ulnar nerve at the elbow [Insufficient Evidence (I), Recommended]; Avoidance of prolonged hyperflexion of the elbow [Insufficient Evidence (I), Recommended]; and Although not particularly successful for neuropathic pain, utilization of NSAIDs [Insufficient Evidence (I), Recommended]. Therefore, without specific documentation of elbow padding, avoidance of leaning on the ulnar nerve at the elbow and avoidance of prolonged hyperflexion of the elbow while sleeping, right ulnar nerve release should not be considered medically necessary, especially considering the borderline condition.

**Right carpal tunnel release:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Initial Care.

**MAXIMUS guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations, Summary.

**Decision rationale:** The patient is a 37 year old male with signs and symptoms of right carpal tunnel syndrome that has failed conservative management of splinting, NSAIDs and a positive response from a steroid injection. The diagnosis of a mild carpal tunnel syndrome is supported by previous EDS. From page 270, ACOEM, Chapter 11, "Surgical decompression of the median nerve usually relieves CTS symptoms. High-quality scientific evidence shows success in the majority of patients with an electrodiagnostically confirmed diagnosis of CTS. Patients with the mildest symptoms display the poorest postsurgery results; patients with moderate or severe CTS have better outcomes from surgery than splinting. CTS must be proved by positive findings on clinical examination and the diagnosis should be supported by nerve-conduction tests before surgery is undertaken. Mild CTS with normal electrodiagnostic studies (EDS) exists, but

moderate or severe CTS with normal EDS is very rare." Further from page 272, Table 11-7, injection of corticosteroids into to the carpal tunnel is recommended in mild to moderate cases of carpal tunnel syndrome after trial of splinting and medication. Therefore, right carpal tunnel release should be considered medically necessary. The UR stated that provocative studies produced pain and that he had not been documented to have failed splinting. There was no documentation of a positive Phalen's or Tinel's sign to support the diagnosis. However, based on the records that were provided for this review, this has been satisfied. The patient was specifically documented to have a positive Phalen's and carpal compression test which produced numbness and tingling. Splinting has been specifically documented as well.

**Bilateral elbow injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Elbow Complaints 2007, Section(s): Lateral Epicondylalgia.

**MAXIMUS guideline:** Decision based on MTUS Elbow Complaints 2007, Section(s): Lateral Epicondylalgia, and Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** The patient has evidence of probable bilateral lateral epicondylitis that has been previously treated with bilateral steroid injections at the time of left sided surgery. This was performed on 9/2/15. A specific response to these injections had not been documented and therefore, further injections should not be considered medically necessary until this has been done or justified. Steroid injections are appropriate for treatment of lateral epicondylalgia, but should have sufficient justification for its use. From Chapter 11, page 270, ACOEM Referral for hand surgery consultation may be indicated for patients who: Have red flags of a serious nature; Fail to respond to conservative management, including worksite modifications; Have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention.