

Case Number:	CM15-0204997		
Date Assigned:	10/21/2015	Date of Injury:	08/17/2013
Decision Date:	12/03/2015	UR Denial Date:	10/09/2015
Priority:	Standard	Application Received:	10/19/2015

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 58-year-old female who sustained an industrial injury on 8/17/13. Injury occurred when she was stepping out of a trailer, holding onto a handle with her right hand, and pulled on her right upper extremity with onset of neck, right shoulder and right arm pain. She underwent right rotator cuff surgery in April 2014. The 4/22/15 EMG/NCV report impression documented an abnormal study with electrophysiologic evidence for bilateral median neuropathy at the wrists consistent with bilateral carpal tunnel syndrome. The 10/5/15 orthopedic surgery report cited worsening bilateral hand pain and numbness, right greater than left. She was dropping things and had frequent volar wrist pain. She had numbness from the right thumb through the ring finger and the left thumb through the middle finger with occasional bilateral small finger numbness. She had right hand spasms where her fingers stuck together and she could not spread them. She had not improved with 8 visits of hand therapy and 3 months of bilateral wrist splinting. Symptoms woke her 3 to 4 times a night and she shook her hands to wake them. Physical exam documented carpal tunnel provocative testing with positive right greater than left Phalen's, Tinel's, and Durkan's carpal tunnel compression, increased volar wrist pain, and finger tingling right 1st-5th digits. Cubital tunnel provocative testing documented positive flinch and jump tests and positive Tinel's, right much greater than the left. There was grip strength weakness on the right 15/10/10 compared to the left 25/30/25 pounds. There was lateral key pinch strength weakness on the right 5/4/6 compared to the left 8/9/9 pounds. The diagnosis was right greater than left carpal tunnel and cubital tunnel syndrome. The electro-diagnostic data on 4/22/15 supports right cubital tunnel syndrome also with noted ulnar

nerve slowing. Authorization was requested for right carpal tunnel release and cubital tunnel release surgery. Records indicated that the right carpal tunnel release was certified. The 10/9/15 utilization review non-certified the right ulnar neurolysis at the elbow as there was no electrodiagnostic evidence of ulnar nerve entrapment at the cubital tunnel and the upper extremity pain was not consistent with the diagnostic of cubital tunnel syndrome. The 10/28/15 orthopedic surgery appeal note indicated that the 4/22/15 NCV study findings documented right ulnar motor velocity slowing with 41.4 at the elbow and 45.7 below the elbow that had not been commented on in the report. The prior EMG/NCV report on 10/9/13 documented bilateral moderate carpal tunnel syndrome, bilateral ulnar neuropathy, and C5 and C6 cervical radiculopathy. Subjective and physical exam findings were unchanged from 10/5/15. The injured worker had a long history of right greater than left hand numbness and signs/symptoms consistent with carpal tunnel and cubital tunnel syndrome. There was electrodiagnostic evidence consistent with right cubital tunnel syndrome. There were positive clinical exam findings and right ulnar intrinsic weakness. She was a candidate for right carpal tunnel release and cubital tunnel release surgery. The right carpal tunnel release had been approved but she wanted both problems addressed. Appeal of the right ulnar neurolysis at the elbow was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right ulnar neurolysis at the elbow: Overturned

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 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 been met. This injured worker presents with worsening right greater than left hand/wrist pain and numbness. There was significant functional difficulty documented with dropping things. Clinical exam findings are consistent with past electrodiagnostic evidence of ulnar neuropathy and current electrodiagnostic evidence of ulnar nerve slowing. There was intrinsic muscle weakness. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.