

<b>Case Number:</b>	CM15-0206872		
<b>Date Assigned:</b>	10/23/2015	<b>Date of Injury:</b>	11/24/2011
<b>Decision Date:</b>	12/08/2015	<b>UR Denial Date:</b>	10/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2015

### 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 61-year-old male who sustained an industrial injury on 11/24/11. Injury occurred when he slipped and fell at work, landing on both elbows. Past medical history was positive for insulin-dependent diabetes. Past surgical history was positive for right shoulder rotator cuff repair, subacromial decompression and Mumford procedure on 11/20/12, right shoulder manipulation with lysis of adhesions and subacromial decompression on 4/16/13, and debridement and decompression of the right ulnar nerve at the elbow on 1/7/15. The 7/14/15 EMG/nerve conduction study impression documented “evidence for an underlying peripheral neuropathy and most likely related to the patient’s diabetes mellitus with more prominent changes over periods of repeated compression at both elbows and both wrists, with the elbow on the left more prominent than the right. Needle examination did not support any specific nerve root impingement or peripheral nerve entrapment.” Left ulnar motor conduction showed prolonged distal latency, a low amplitude response above the elbow, and moderate slowing of the conduction velocity. Left ulnar sensory conduction showed prolonged peak latency and normal amplitude response. The 8/12/15 agreed medical examination report discussed the electrodiagnostic study of 7/14/15. The injured worker presented only with positive findings for the right elbow and not the left. He did not have symptoms in the left upper extremity consistent with the diagnostic study findings which are probably subclinical and not of significance. The 9/11/15 treating physician report indicated that the injured worker was 7 months status post right shoulder labral debridement with rotator cuff repair and right ulnar nerve decompression at the elbow. A recent EMG showed severe right carpal tunnel syndrome with no ulnar neuropathy. There was continued bilateral hand pain and numbness, left greater than right, and right shoulder

pain and stiffness. Numbness was noted in the ulnar distribution on the right and in the whole hand on the left. Left upper extremity exam documented positive elbow flexion test, positive Tinel's at the carpal tunnel, and no intrinsic weakness or clawing. Medications included Percocet, Vicodin, Motrin, and Ambien. The diagnosis included bilateral ulnar neuritis at the elbow, left greater than right. The injured worker was having a lot of symptoms on the left and wanted to proceed with left ulnar nerve surgery and left carpal tunnel surgery. Authorization was requested for left cubital tunnel release with possible anterior transposition and post-operative physical therapy three times a week for 3 weeks. The 10/7/15 utilization review non-certified the request for left carpal tunnel release with possible anterior transposition and associated post-operative physical therapy as the diagnosis of ulnar nerve entrapment was not established by electrodiagnostic studies or clinical exam findings.

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

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

#### **Left cubital tunnel release with possible anterior transposition: 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 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. The injured worker presents with left hand pain with numbness over the whole hand and a positive elbow flexion test. Electrodiagnostic findings documented upper extremity findings consistent with peripheral neuropathy likely relative to his diabetes with some slowing of left ulnar motor conduction velocity. Detailed evidence of up to 3 to 6 months of a recent, reasonable and/or comprehensive 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 3 times a week for 3 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.