

<b>Case Number:</b>	CM15-0052428		
<b>Date Assigned:</b>	04/14/2015	<b>Date of Injury:</b>	07/06/2011
<b>Decision Date:</b>	05/13/2015	<b>UR Denial Date:</b>	03/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/19/2015

### 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:

The injured worker is a 41-year-old male who sustained an industrial injury on 7/06/11. Injury occurred while he was trimming a hedge and fell from a ladder about 8 feet off the ground. He landed on a rail with immediate onset of right knee, arm and shoulder pain. The 9/5/11 right elbow MRI demonstrated mild tendinosis at the distal aspect of the biceps tendon without significant tear, very low-grade intrasubstance tear of the extensor tendons at their humeral attachment, moderate tendinosis at the distal aspect of the triceps tendon near its olecranon attachment, high-grade tear of the radial collateral ligament at this humeral attachments, and mild thickening of the lateral ulnar collateral ligament, suggesting chronic injury. The 11/26/14 right shoulder MR arthrogram demonstrated an inferior labral tear. The 12/23/14 electrodiagnostic testing documented bilateral mild to moderate median neuropathy at the carpal tunnel region, and mild ulnar motor neuropathy at the cubital tunnel. The 12/5/14 treating physician report documented right elbow numbness and tingling to the hand with the hand locking up. He reported shaking the hand frequently. Physical exam documented positive right elbow tenderness at the medial and lateral epicondyles, positive cubital tunnel tenderness, and positive Tinel's. Right wrist/hand exam documented negative Tinel's and Phalen's, positive carpal tunnel compression, and decreased sensation right index and little fingers. The 1/15/15 progress report cited worsening right shoulder pain and increased night pain. Physical exam documented tenderness to palpation over the right ulnar nerve, spasticity, and positive Tinel's test right ulnar nerve. There is tenderness to palpation over the right carpal tunnel, and positive Tinel's and

Phalen's tests. There was limited right shoulder range of motion, positive impingement signs, and acromioclavicular joint tenderness to palpation. There was a positive lift off test with subscapularis pain. MR arthrogram was positive for right shoulder acromioclavicular joint degenerative joint disease. The diagnosis included right cubital tunnel syndrome and moderate carpal tunnel syndrome. The treatment plan recommended a consult with an upper extremity specialist. The 2/2/15 agreed medical examiner report cited severe shoulder pain associated with raising his elbow up above and away from his body and intermittent pain that woke him at night. There was intermittent grade 8/10 right elbow pain with numbness throughout the entire right forearm to the fingers. He reported the elbow intermittently locked up and was unable to bend. He reported numbness and pain in the right hand which locked up in a claw position 1 to 6 times a day. There was right hand numbness without any specific dermatome or nerve distribution. Medications included Vicodin and ibuprofen. Right shoulder exam documented significant loss of motion, 4/5 abduction weakness, and positive Speed's, Neer's and Hawkins' tests. Right elbow exam documented medial and lateral epicondyle and ulnar nerve tenderness to palpation, with mild loss in motion. Right wrist exam documented mild range of motion loss and 4/5 flexion/extension strength. There was full finger range of motion with decreased sensation throughout. Two-point discrimination was not reliable. Grip strength was 30/30/40 right, 80/90/90 left. Sensory exam documented decreased sensation in the median and ulnar distributions, and normal deep tendon reflexes. The diagnosis was right carpal tunnel syndrome, right elbow pain, and right shoulder impingement, rotator cuff tendinitis, and labral tear. The treatment plan included consideration for carpal tunnel decompression, and right shoulder subacromial decompression and bursectomy. A request for authorization of right carpal tunnel syndrome, cubital tunnel decompression with submuscular transposition, and post-op therapy 3x4 was submitted on 3/11/15. The 3/18/15 utilization review non-certified the request for right carpal tunnel release as there was no detailed evidence of comprehensive conservative treatment. The request for cubital tunnel decompression with submuscular transposition was non-certified as there was no clear description of rendered treatment for cubital tunnel syndrome or discussion of ulnar nerve subluxation requiring transposition. The request for post-op physical therapy 3x4 was non-certified as the associated surgical requests was not medically necessary.

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

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

**Right carpal tunnel release:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 270-271, 603-06. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome, Elbow chapter, ACOEM Chapter 7 - Independent Medical Examinations And Consultations, Pain chapter (pages 127, 156).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270.

**Decision rationale:** The California MTUS guidelines state that carpal tunnel syndrome should be proved by positive findings on clinical exam and the diagnosis should be supported by nerve conduction tests before surgery is undertaken. Guideline criteria have been reasonably met. This

injured worker presents with signs/symptoms, provocative testing and electrodiagnostic evidence of carpal tunnel syndrome. Conservative treatment is documented in the records to include anti-inflammatory and activity modification. Given the severity of the symptoms, proceeding with surgery seems reasonable although conservative treatment evidence is limited. Therefore, this request is medically necessary.

**Cubital tunnel decompression with submuscular transposition:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271, 603-06. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome, Elbow chapter, ACOEM Chapter 7 - Independent Medical Examinations and Consultations, Pain chapter (pages 127, 156).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 36-37.

**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 reasonably met. This injured worker presents with clinical and electrodiagnostic findings that correlate with evidence of cubital tunnel syndrome. A reasonable non-operative protocol trial and failure has been submitted. Therefore, this request is medically necessary.

**Post-op therapy 3x4 weeks:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 15-16.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 15-16, 18.

**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. The recommended general course for cubital tunnel release is 20 visits over 10 weeks during a 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 10 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the post-surgical physical medicine period. This is the initial request for post-operative physical therapy and, although it exceeds recommendations for initial care, is within the recommended general course. Therefore, this request for is medically necessary.