

Case Number:	CM15-0086545		
Date Assigned:	05/08/2015	Date of Injury:	02/04/2013
Decision Date:	06/30/2015	UR Denial Date:	04/18/2015
Priority:	Standard	Application Received:	05/05/2015

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 61-year-old female who sustained an industrial injury on 2/4/13. The mechanism of injury was not documented. She underwent right cubital and carpal tunnel releases on 5/9/13, and open comprehensive cubital tunnel release with anterior transposition due to ulnar nerve instability and left carpal tunnel release on 9/18/14. Extensive post-operative occupational therapy was noted. The 1/9/15 bilateral upper extremity electrodiagnostic study report documented clinical exam findings of positive Tinel's at the right wrist and elbow, decreased right hand sensation, and 4/5 hand grip and finger abduction strength. The study impression documented findings of right carpal tunnel syndrome, improved compared to the 2/25/13 study. There was right ulnar neuropathy across the elbow, with the ulnar motor nerve somewhat slower across the elbow compared to previous study. There was no EMG evidence of denervation potentials in the rest of the upper extremity muscles tests. The 1/26/15 treating physician report cited unchanged right arm pain, weakness and numbness. Physical exam documented diffuse hypesthesia, which was fairly significant over the right hand. The electrodiagnostic study showed improved right median neuropathy but worse ulnar neuropathy. Revision cubital tunnel and carpal tunnel release surgeries were recommended. She remained temporarily totally disabled. The 3/17/15 primary treating physician appeal report cited intermittent to constant, mild to severe, right arm pain. Pain was worse during activity. There was no change in the level of function during activity. Medications included Motrin. Right hand exam documented profound hypesthesia to the thumb, index, long and ring fingers with slight sensation in the right little finger. The diagnosis included bilateral cubital tunnel and carpal tunnel syndrome. The left upper extremity was improving following surgery. The surgery on the right side had failed as proven by the EMG/nerve conduction study showing that there was been

worsening. Appeal of the surgery was requested as the injured worker had a successful outcome with the left upper extremity surgery. There was a chance that with prolonged denial her nerve damage may become permanent and she may never recover even by surgery. Authorization was requested for right elbow revision ulnar nerve decompression and transposition, revision of right carpal tunnel release, sling, cock-up splint, and 8 sessions of post-op physical therapy for the right wrist and elbow. The 4/15/15 utilization review non-certified the right revision ulnar nerve decompression and transposition and carpal tunnel release, with associated surgical requests as there was no documentation of failed conservative treatment, clinical exam tests, or EMG/nerve conduction study report. The 4/21/15 treating physician report cited intermittent moderate right arm pain with numbness, stiffness, tingling and weakness. Symptoms were aggravated with repetitive use. The injured worker was limiting activity and using Motrin for pain management. Right hand exam documented diffuse hypesthesia and intrinsic 4+/5 weakness. She was getting more weakness on the right hand due to chronic ulnar nerve compression. The request for revision surgery was pending. She was unable to return to work as a telephone triage RN until she was able to use her right arm.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Elbow Revision Ulnar Nerve Decompression and Transposition: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints.

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 met. This injured worker presents with persistent right arm pain, numbness, tingling and weakness. Clinical exam findings are consistent with electrodiagnostic evidence of worsened right ulnar neuropathy. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Revision Right Carpal Tunnel Release: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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. Criteria include failure to respond to conservative management, including worksite modification. Guideline criteria have been met. This injured worker presents with persistent right arm pain, numbness, tingling and weakness. Clinical exam findings are consistent with electrodiagnostic evidence of persistent right carpal tunnel syndrome. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Associated Surgical Services: DME: Sling, Cock up Splint: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 41-42, 264, 272.

Decision rationale: The California MTUS guidelines generally support the use of a sling and cock-up splint for short-term use in the post-operative period. Therefore, this request is medically necessary.

Post-Operative Physical Therapy for the Right Wrists and Elbow (8-sessions, 2 times a week for 4 weeks): Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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. 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. 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 postsurgical physical medicine period. This request for physical therapy is consistent with guidelines recommendations for initial post-operative treatment. Therefore, this request is medically necessary.