Case Number:	CM14-0160585		
Date Assigned:	10/06/2014	**Date of Injury:**	05/03/2014
Decision Date:	10/31/2014	**UR Denial Date:**	09/12/2014
Priority:	Standard	**Application Received:**	09/30/2014

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. The expert reviewer is Board Certified in Orthopaedic Surgery and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 32-year-old female with a date of injury of 5/3/14. She reported an onset of left upper extremity pain pushing 8 shopping carts to the front of the store. The 7/28/14 left upper extremity electromyogram/nerve conduction velocity study was reported as normal. There was no electrophysiologic evidence of left carpal, radial or cubital tunnel syndrome, or cervical radiculopathy. The 8/20/14 treating physician report cited worsening left cubital tunnel symptoms despite being on restricted duty with no use of the left arm, and completion of 8 visits of physical therapy. She was using an elbow splint and trying to avoid sustained elbow flexion. Her left cubital tunnel symptoms were by far the most significant problem, worse that the left carpal tunnel syndrome or the right arm. Her subjective symptoms were exaggerated and she was emotionally labile. Her nerve conduction study was interpreted as negative but careful inspection of the median to ulnar distal motor latency difference was 1.3 which would be consistent with borderline carpal tunnel syndrome. There was no evidence of carpal tunnel syndrome with regard to sensory latency. There was no electrodiagnostic evidence of cubital tunnel syndrome. Left upper extremity exam documented the left ulnar nerve to be very swollen, tender and taut. Tinel's test was positive with paresthesias into the ring and small finger. Ulnar nerve compression test was strongly positive. There was guarding of the elbow and she would not flex it more than 95 to 100 degenerative because of pain and anticipation of pain. Functional testing of the small finger was reduced compared to median nerve distribution. Ulnar intrinsic muscle strength was intact and there was no atrophy. Tinel's and Phalen's were negative for carpal tunnel syndrome. Resisted provocative testing for medial epicondylar pain was submaximal in effort and negative. The diagnosis was bilateral cubital much worse than carpal tunnel syndrome. The injured worker had failed conservative treatment including therapy, medications, elbow splinting, work restrictions, and ergonomic and behavioral modifications. The treatment plan recommended left

carpal tunnel release and in situ ulnar nerve root decompression with possible transposition and tendon lengthening if the nerve was too tight or unstable intraoperatively. Concern was raised for her emotional state and Neurontin was prescribed to avoid complex regional pain syndrome. The 9/12/14 utilization review modified the request for ulnar nerve decompression with possible transposition and tendon lengthening to ulnar nerve decompression only as there was no evidence of nerve subluxation on exam. The request for carpal tunnel release was denied based on lack of nerve conduction study evidence. The request for post-op physical therapy was listed as denied on the cover sheet but was certified in the rationale.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left CTR and ulnar nerve decompression with transposition and lengthening: Upheld

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 11 Forearm, Wrist, and Hand Complaints Page(s): 270.

Decision rationale: The American College of Occupational and Environmental Medicine 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. 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 worker 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 36 months of conservative care should precede a decision to operate. Guideline criteria have not been met. There is no clear evidence of carpal tunnel syndrome on the clinical exam and the electromyogram/nerve conduction study was normal. The clinical exam is strongly positive for cubital tunnel syndrome but not supported by electrodiagnostic evidence. Symptoms were reported as exaggerated and exam participation submaximal. Therefore, this request is not medically necessary.