

Case Number:	CM13-0014088		
Date Assigned:	10/02/2013	Date of Injury:	06/13/2010
Decision Date:	01/23/2014	UR Denial Date:	08/05/2013
Priority:	Standard	Application Received:	08/21/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Pennsylvania. 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 physician 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 patient is a 27-year-old with reports of bilateral upper extremity pain, left greater than right. He underwent electrodiagnostic studies in May of 2011, which were normal. However, he later underwent repeat electrodiagnostic studies in April of 2012, which showed a moderately severe right carpal tunnel syndrome and a mild left carpal tunnel syndrome. The patient did not have ulnar neuropathy according to the records. The patient over time appears to have primary complaints relating to carpal tunnel syndrome, which has been treated with medication therapy, bracing, and injection. However, the records also suggest another potential diagnosis including medial and lateral epicondylitis of the elbows, de Quervain's syndrome, and ulnar neuritis. More recently, the patient was reported to have findings of an early complex regional pain syndrome when evaluated on 09/05/13. The patient additionally has significant psychiatric issues and has been under recent care. The current request is for multiple surgical procedures including left elbow anterior transposition, left carpal tunnel release, and left de Quervain's release.

IMR ISSUES, DECISIONS AND RATIONALES

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

left elbow anterior transposition: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 603-666.

Decision rationale: The combination of all these surgical procedures cannot be recommended as necessary according to the records reviewed. They would not be recommended for multiple reasons. First, the patient was recently reported to have complex regional pain syndrome on 09/05/13, which would generally contraindicate surgery. In addition, while the patient may be a candidate for a left carpal tunnel release, the medical necessity of the left elbow cubital tunnel release and left de Quervain's release remains yet to be established. The left elbow procedure has been requested in the absence of cubital tunnel syndrome confirmed by electrodiagnostic studies. Also, the most recent evaluation on 09/05/13 did not indicate a diagnosis of cubital tunnel syndrome for the patient. Furthermore, there is a confounding history noted on 07/08/10 that suggests the patient was stabbed in the left proximal forearm and had left ulnar nerve damage. The relationship to the patient's current symptoms is not entirely discussed. Finally, the extent of conservative treatment for the patient's potential ulnar neuropathy as well as the conservative treatment for de Quervain's tenosynovitis is not entirely delineated. Specifically, a corticosteroid injection for de Quervain's syndrome is generally required before surgical release. The records suggest that the patient may have had injections of the carpal tunnel, and it is not clear if the patient underwent a de Quervain's injection. Notably, the patient at one point had symptoms on the sixth dorsal compartment, but de Quervain's tendinosis involves the first dorsal compartment and I am not certain whether that area was injected. For all these reasons, the requested surgery with all of these different interventions cannot be recommended as medically necessary based on the information reviewed.

left CTR with Flexor Tenosynovectomy:

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

Decision rationale: The combination of all these surgical procedures cannot be recommended as necessary according to the records reviewed. They would not be recommended for multiple reasons. First, the patient was recently reported to have complex regional pain syndrome on 09/05/13, which would generally contraindicate surgery. In addition, while the patient may be a candidate for a left carpal tunnel release, the medical necessity of the left elbow cubital tunnel release and left de Quervain's release remains yet to be established. The left elbow procedure has been requested in the absence of cubital tunnel syndrome by electrodiagnostic studies. Also, the most recent evaluation on 09/05/13 did not indicate a diagnosis of cubital tunnel syndrome for the patient. Furthermore, there is a confounding history noted on 07/08/10 that suggests the patient was stabbed in the left proximal forearm and had left ulnar nerve damage. The relationship to the patient's current symptoms is not entirely discussed. Finally, the extent of conservative treatment for the patient's potential ulnar neuropathy as well as the conservative treatment for de Quervain's tenosynovitis is not entirely delineated. Specifically, a corticosteroid injection for de Quervain's syndrome is generally required before surgical release. The records

suggest that the patient may have had injections of the carpal tunnel, and it is not clear if the patient underwent a de Quervain's injection. Notably, the patient at one point had symptoms on the sixth dorsal compartment, but de Quervain's tendinosis involves the first dorsal compartment and I am not certain whether that area was injected. For all these reasons, the requested surgery with all of these different interventions cannot be recommended as medically necessary based on the information reviewed.

left DeQuervain's Release: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

Decision rationale: The combination of all these surgical procedures cannot be recommended as necessary according to the records reviewed. They would not be recommended for multiple reasons. First, the patient was recently reported to have complex regional pain syndrome on 09/05/13, which would generally contraindicate surgery. In addition, while the patient may be a candidate for a left carpal tunnel release, the medical necessity of the left elbow cubital tunnel release and left de Quervain's release remains yet to be established. The left elbow procedure has been requested in the absence of cubital tunnel syndrome by electrodiagnostic studies. Also, the most recent evaluation on 09/05/13 did not indicate a diagnosis of cubital tunnel syndrome for the patient. Furthermore, there is a confounding history noted on 07/08/10 that suggests the patient was stabbed in the left proximal forearm and had left ulnar nerve damage. The relationship to the patient's current symptoms is not entirely discussed. Finally, the extent of conservative treatment for the patient's potential ulnar neuropathy as well as the conservative treatment for de Quervain's tenosynovitis is not entirely delineated. Specifically, a corticosteroid injection for de Quervain's syndrome is generally required before surgical release. The records suggest that the patient may have had injections of the carpal tunnel, and it is not clear if the patient underwent a de Quervain's injection. Notably, the patient at one point had symptoms on the sixth dorsal compartment, but de Quervain's tendinosis involves the first dorsal compartment and I am not certain whether that area was injected. For all these reasons, the requested surgery with all of these different interventions cannot be recommended as medically necessary based on the information reviewed.