

<b>Case Number:</b>	CM13-0023530		
<b>Date Assigned:</b>	06/06/2014	<b>Date of Injury:</b>	09/09/2010
<b>Decision Date:</b>	08/05/2014	<b>UR Denial Date:</b>	08/28/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/12/2013

### 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 Orthopedic Surgery and is licensed to practice in California. 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:

50 year-old-claimant with industrial injury reported on 9/9/10. Status post left carpal tunnel release and left cubital tunnel release on 11/27/12. Exam note 8/20/13 demonstrates patient with report of complete numbness in the left hand. Report demonstrates atrophy of the left thenar muscles and positive Tinel's and positive Phalen's test. Report is made of small ganglion cyst of the left volar radial wrist. Electrodiagnostic studies from 8/5/13 demonstrate report of focal neuropathy of the left ulnar nerve and no evidence of median or radial neuropathy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1. LEFT VOLAR WRIST GANGLION EXCISION, LEFT REDO CTR/MEDIAN NERVE BLOCK, FLEXOR SYNOVECTOMY, MEDIAN NERVE INTERNAL NEURALYSIS, HYPOTHENAR FAT FLAP:** Upheld

**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): 271.

**Decision rationale:** According to the California Medical Treatment Utilization Schedule (MTUS)/American College of Occupational and Environmental Medicine (ACOEM), 2nd

Edition, (2004) guidelines, Chapter 11, Forearm, Wrist and Hand conditions, page 271, ganglion excision is recommended after aspiration has failed to resolve the condition. As the exam notes from 8/20/13 demonstrating an attempt at aspiration. The treatment is not medically necessary and appropriate.

**2. LEFT ULNAR NERVE DECOMPRESSION AT ELBOW ( REDO) WITH POSSIBLE INTERNAL NEURALYSIS, LEFT 1ST DC RELEASE AND LEFT ECU SHEATH RECONSTRUCTION.: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow section, surgery for cubital tunnel syndrome.

**Decision rationale:** According to the California Medical Treatment Utilization Schedule (MTUS)/American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) is silent on the issue of surgery for cubital tunnel syndrome. According to the Official Disability Guidelines (ODG), Elbow section, Surgery for cubital tunnel syndrome, indications include exercise, activity modification, medications and elbow pad and or night splint for a 3 month trial period. In this case there is insufficient evidence in the records from 8/5/13 that the claimant has satisfied these criteria in the cited records. There is insufficient evidence also of failure of conservative management for the left wrist. The treatment is not medically necessary and appropriate.

**3. PURCHASE OF VASCUTHERM 4 WITH COLD/HEAT THERAPY & COMPRESSION: 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.

**4. POST OP PHYSICAL THERAPY 3X4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**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.

**SPLINT TO BE DISPENSED AT POST OP VISIT.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 156.

**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.