

<b>Case Number:</b>	CM13-0040103		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	07/14/2010
<b>Decision Date:</b>	02/10/2014	<b>UR Denial Date:</b>	09/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2013

### 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 Plastic and Reconstructive Surgery and is licensed to practice in Maryland. 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 49 year old female with a reported date of work-related injury of 7/14/2010. The patient is well-documented to have signs and symptoms of right carpal tunnel syndrome, right cubital tunnel syndrome and right DeQuervain's tenosynovitis. From a progress note dated October 1, 2013, she is noted to have persistent numbness in her bilateral hands on the radial and ulnar sides. She has pain along the radial aspect of her wrist that wakes her up at night. Examination notes decreased sensation over radial and ulnar digits. There is positive Tinel's and Phalen's sign across the wrist as well as positive Tinel's at the elbow and positive Finkelstein's. There is pain over the 1st dorsal extensor compartment. On 6/7/13 electrodiagnostic studies report Right median nerve compromise and borderline right ulnar nerve compromise at the elbow. Her symptoms have been present for 3 years. Non operative therapy has included physical therapy, cortisone injections, NSAIDs, activity modification and bracing. AME reports 8/13/13 and 8/27/13 support the overall findings of the treating physician and recommend upper extremity evaluation and possible carpal tunnel release. On 9/10/13, the patient requested surgical treatment of her right wrist to include carpal tunnel release, ulnar nerve transposition at the elbow and treatment of her DeQuervain's tenosynovitis. UR dated 9/25/13 for these surgeries was denied but modified. Reason given was that after conferring with the requesting surgeon "He is not requesting any surgery at this time." "As he was not requesting any surgery, he recommended a follow-up visit for re-evaluation. Non-certify the surgical requests conditionally based upon reevaluation." Upon further evaluation, the surgeries were requested again. Request dated 11/7/13 certifies surgery treatment of Right Carpal Tunnel Release, Ulnar Nerve transposition of the elbow, and release of the DeQuervain. The patient underwent right carpal tunnel release a

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Surgery Right Wrist-Carpal Tunnel Release, Ulnar Nerve Transposition at Elbow and Release of the De Quervain: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 253-286. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Procedure summary, Forearm, wrist and hand DeQuervain's tenosynovitis

**Decision rationale:** From ACOEM elbow complaints chapter page 37, '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. Before proceeding with surgery, patients must be apprised of all possible complications, including wound infections, anesthetic complications, nerve damage, and the high possibility that surgery will not relieve symptoms. Absent findings of severe neuropathy such as muscle wasting, at least 3-6 months of conservative care should precede a decision to operate.' In my opinion and supported by the medical record this is present. The patient has signs and symptoms of ulnar cubital tunnel syndrome that is supported by electrodiagnostic studies. She has failed non-operative management over a greater than 6 month history. Thus, based on this she would qualify for surgical treatment as was later certified. From American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Ch. 11, page(s) 269 Table 11-6, history and physical examination provide '++++' and '+++ (Number of plus signs indicates relative ability to identify or define pathology).respectively in identifying wrist/hand pathology for carpal tunnel syndrome. Electrodiagnostic studies provide '++++' as well. From page 270, 'Surgical decompression of the median nerve usually relieves CTS symptoms. High quality scientific evidence shows success in the majority of patients with an electrodiagnostically confirmed diagnosis of CTS.' In my opinion and supported by the medical record this is present. The patient has signs and symptoms of right carpal tunnel syndrome that is supported by electrodiagnostic studies. She has failed non-operative management over a greater than 6 month history. Thus, based on this she would qualify for surgical treatment as was later certified. From ACOEM p 271, the majority of patients with DeQuervain's syndrome will have resolution of symptoms with conservative treatment. Under unusual circumstances of persistent pain at the wrist and limitation of function, surgery may be an option for treating DeQuervain's tendinitis. From ODG, surgery is recommended as an option if consistent symptoms, signs, and failed three months of conservative care with splinting and injection. de Quervain's disease causes inflammation of the tendons that control the thumb causing pain with thumb motion, swelling over the wrist, and a popping sensation. Surgical treatment of de Quervain's tenosynovitis or

