

Case Number:	CM13-0064367		
Date Assigned:	01/03/2014	Date of Injury:	02/19/2010
Decision Date:	06/25/2014	UR Denial Date:	11/21/2013
Priority:	Standard	Application Received:	12/11/2013

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 Plastic Surgery and Hand Surgery, and is licensed to practice in Oregon. 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 patient has undergone right ulnar nerve release, right elbow arthroscopy, and right lateral epicondyle debridement on 1/24/11. He continues to have symptomatic ulnar nerve subluxation. He also has numbness and tingling in the median nerve distribution. Electrodiagnostic testing was done on September 16, 2010; the bilateral upper extremity findings were consistent with bilateral carpal tunnel syndrome and relative slowing of the conduction velocity ulnar nerve motor component cross elbow segment bilaterally. Also noted was a mild delay of the left ulnar sensory distal latency through Guyon's canal. Bilateral upper extremity electrodiagnostic testing was done on June 28, 2012. Slight carpal tunnel syndrome was indicated on nerve conductions with minimal abnormalities. The patient has radial sided wrist pain. His surgeon recommends revision ulnar nerve surgery and carpal tunnel release.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT CARPAL TUNNEL RELEASE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, 11-7

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

Decision rationale: According to the ACOEM guidelines, Chapter 11, page 270, surgical decompression of the median nerve usually relieves carpal tunnel syndrome (CTS) symptoms. High-quality scientific evidence shows success in the majority of patients with an electrodiagnostically confirmed diagnosis of CTS. Patients with the mildest symptoms display the poorest post-surgery results; patients with moderate or severe CTS have better outcomes from surgery than splinting. CTS must be proved by positive findings on clinical examination and the diagnosis should be supported by nerve-conduction tests before surgery is undertaken. The patient's last nerve conduction test was in 2012 and showed slight carpal tunnel. Exam findings consistent with more advanced carpal tunnel are not presented. He uses a walker, which may be placing pressure on his median nerves and likely would be unrelieved with carpal tunnel release. As such, the request is not medically necessary.

REVISION ULNAR NERVE TRANSPOSITION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, , 36-38

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 37.

Decision rationale: The patient is said to have a symptomatic subluxing ulnar nerve. Per the ACOEM guidelines, 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. The records do not document the nature of the patient's symptoms, attempts at conservative care, or a recent nerve conduction test. As such, the request is not medically necessary.

1ST DORSAL COMPARTMENT RELEASE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, , 264, 271

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) FOREARM, WRIST AND HAND, DEQUERVAINS

Decision rationale: The surgeon's note dated 10/23/13 indicates a steroid injection was given for DeQuervain's. Follow-up to determine the outcome of the injection is not provided. According to the Official Disability Guidelines, surgery for DeQuervain's tenosynovitis is recommended as an option if there are consistent symptoms, signs, and failed three months of conservative care with splinting and injection. DeQuervain'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 DeQuervain's tenosynovitis or hand and wrist tendinitis/tenosynovitis without a trial of conservative therapy, including a work evaluation, is generally not indicated. 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. The records do not document the failure of the steroid injection and thumb splinting. As such, the request is not medically necessary.

PREOP LABS (CBC, BMP, EKG, CHEST XRAY): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OTHER MEDICAL TREATMENT GUIDELINE OR MEDICAL EVIDENCE: PRACTICE ADVISORY FOR PREANESTHESIA EVALUATION. AN UPDATED REPORT BY THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS TASK FORCE ON PREANESTHESIA EVALUATION." (AMERICAN SOCIETY OF ANESTHESIOLOGISTS TASK FORCE ON PREANESTHESIA EVALUATION. ANESTHESIOLOGY. 2012 MAR;116(3):522-38)

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

POST OPERATIVE PHYSICAL THERAPY TWICE A WEEK FOR SIX WEEKS:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: POST SURGICAL TREATMENT GUIDELINES, ,

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain Medical Treatment Guidelines Post Treatment Guidelines Acupuncture Medical Treatment Guidelines pages 16 and 17

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.