

Case Number:	CM13-0066227		
Date Assigned:	01/03/2014	Date of Injury:	07/14/2011
Decision Date:	09/08/2014	UR Denial Date:	11/18/2013
Priority:	Standard	Application Received:	12/16/2013

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 and Reconstructive Surgery and is licensed to practice in Maryland, North Carolina, and Virginia. 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 is a 43 year old female with a reported date of injury on 7/14/11 who is diagnosed with left wrist pain, carpal tunnel and cubital tunnel syndrome. Recommendation was made for left wrist arthroscopy, left carpal tunnel release, left Guyon's canal decompression, left revision ulnar nerve decompression with intramuscular transposition, physical therapy and CBC for preoperative testing. Options presented to the patient included continued splinting, injections, no surgery and cervical spine work-up. Documentation from progress note dated 11/11/13 notes medial elbow tenderness, diminished grip strength in the left hand, and good range of motion of the left wrist and elbow. The patient is considering surgical options. Documentation from the requesting surgeon on 11/4/13 notes the patient had undergone left endoscopic cubital tunnel release and left lateral epicondyle debridement on 6/6/12. Electrodiagnostic studies from 2/13 confirmed persistent left cubital tunnel syndrome. MRI dated 5/13 is stated to have shown a TFCC tear. Based on previous history and examination, the patient is noted to have left recurrent cubital tunnel syndrome, left carpal tunnel syndrome, left-sided DeQuervain's disease, left sided ECU tendinitis and left radial-sided wrist pain. She was treated with NSAIDs and nocturnal splints, as well as a steroid injection into the left first dorsal extensor compartment and left wrist radial carpal joint. This improved her significantly as the 'wrist pain seems to be gone.' She has persistent numbness and tingling at the left small and ring finger that is constant. She has intermittent numbness and tingling at the thumb to middle finger. Pain at the wrist is not completely resolved. Examination notes left positive carpal tunnel Tinel's test and cubital tunnel Tinel's test. The volar wrist flexion compression test and the elbow flexion compression test were positive. Tinel's test over the Guyon's canal was positive. At the wrist, the snuffbox and dorsal scapholunate ligament were still tender, but less than her initial exam. Surgical treatment was recommended. Electrodiagnostic studies from 10/21/13 note normal EMG findings, but a

moderate left ulnar neuropathy at the level of the elbow and a minimal right carpal tunnel syndrome. Documentation from 9/23/13 notes the patient has full range of motion of the elbow, wrist, fingers and thumb. The left elbow is non-tender. At the wrist, there is tenderness at the snuffbox, dorsal scapholunate ligament and with a Watson's test. Although the MRI identified a partial scapholunate tear, there was no obvious diastasis on x-ray. The patient was administered steroid injection into the left first dorsal extensor compartment, ECU tendon sheath and radiocarpal joint. A thumb spica splint was given to the patient to be worn. The patient was to continue with NSAIDs. Electrodiagnostic studies from 2/11/13 note left ulnar neuropathy across the elbow and normal EMG findings. Previous CBC was noted to be normal from 7/17/13(except for eosinophil percentage which was slightly elevated). MRI examination of the neck from 7/11/13 notes mild disc desiccation at C2-C3, C3-C4, C4-C5, C5-C6 levels and minimal disc bulging at the C5-C6 level. There is no significant spinal canal stenosis, neural foraminal narrowing, nerve root impingement or spinal cord compression. Documentation from 6/6/13 notes the patient underwent a steroid injection into the left 1st and 6th dorsal compartment. Recommendation was made for arthroscopy of the left wrist with synovectomy and possible repair of the scapholunate ligament. A second opinion was recommended. MR arthrogram of the left wrist 5/28/13 notes 'slit-like central perforation of the TFCC' and tear of the scapholunate ligament. Qualified medical examination dated 5/3/13 notes history of left endoscopic cubital tunnel release with lateral fasciectomy and extensor origin detachment on 6/6/12 and ulnar nerve transposition of the left elbow on 1/4/13. She had 50% improvement of her symptoms after the second surgery but continued with paresthesias of the small finger and ulnar half of the ring finger. She has no elbow pain currently. Tinel's sign is positive over the left elbow. She is considered permanent and stationary for her left elbow and no further surgical intervention was recommended. She may require further treatment of the left wrist to include steroids and possible surgical treatment. Utilization review dated 11/18/13 did not certify the procedures of left wrist arthroscopy with repair, left carpal tunnel release and Guyon's canal decompression, left revision ulnar nerve decompression with intramuscular transposition, physical therapy x 12 and diagnostic testing, pre-op labs-CBC.

IMR ISSUES, DECISIONS AND RATIONALES

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

WRIST ARTHROSCOPY WITH REPAIR TO ALL DAMAGED STRUCTURES: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist and Hand, Diagnostic Arthroscopy.

Decision rationale: From ODG, Forearm, wrist and hand, Diagnostic Arthroscopy: Recommended as an option if negative results on imaging, but symptoms continue after 4-12 weeks of conservative treatment. This study assessed the role of diagnostic arthroscopy following a wrist injury in patients with normal standard radiographs, an unclear clinical diagnosis and persistent severe pain at 4 to 12 weeks. Patients with marked persistent post-

traumatic symptoms despite conservative management are likely to have sustained ligament injuries despite normal radiographs. It is recommended that under these circumstances an arthroscopy may be carried out as soon as 4 weeks if the patient and surgeon wish to acutely repair significant ligament injuries. (Adolfsson, 2004) The patient has responded significantly to conservative management of steroid injection and splinting as outlined in the documentation as the 'wrist pain seems to be gone'; although it has not completely resolved. With this response to conservative management, further conservative management should be considered. This could include repeat injection, continued splinting and possible physical therapy. Once a clear failure of non-operative management has been documented, then consideration for diagnostic arthroscopy and repair should be given. The patient has 2 findings on MRI examination, including a TFCC tear and partial scapholunate tear that could help to explain her pain. However, the patient has radial-sided pain and TFCC tears generally present as ulnar-sided pain. Further, there is ambiguity about the severity and clinical significance of the partial scapholunate tear as the X-rays do not show diastasis. She showed a good response in this area from steroid injection and splinting and thus further time, possible additional steroid injection, splinting, and physical therapy should be considered as well. From ACOEM, Referral for hand surgery consultation may be indicated for patients who:- Have red flags of a serious nature- Fail to respond to conservative management, including worksite modifications- Have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention. The patient is not documented to have red flags of a serious nature. She has responded to conservative management. Thus, left wrist arthroscopy and repair is not medically necessary at this time.

LEFT CARPAL TUNNEL RELEASE, GUYON'S CANAL DECOMPRESSION: Upheld

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

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

Decision rationale: The patient has some signs and symptoms of carpal tunnel syndrome but this is not supported by electrodiagnostic studies from 10/21/13. They note normal EMG findings, but a moderate left ulnar neuropathy at the level of the elbow and a minimal right carpal tunnel syndrome. Thus without electrodiagnostic studies supporting median nerve and ulnar nerve neuropathy at the wrist, these procedures should not be considered medically necessary. From ACOEM, page 270, 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 request for left carpal tunnel release, Guyon's canal decompression is not medically necessary.

PHYSICAL THERAPY, YWELVE SESSIONS: 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.

DIAGNOSTIC TESTING, PRE-OPERATIVE LABS- CBC: 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.

LEFT REVISION ULNAR NERVE DECOMPRESSION WITH INTRAMUSCULAR TRANSPOSITION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Wheelless' Textbook or Orthopedics - Cubital Tunnel Syndrome.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 36-38.

Decision rationale: From ACOEM, Elbow complaints, with respect to ulnar nerve entrapment, Evidence is lacking that any of these surgeries has advantages over conservative treatment. The simple ulnar nerve release does have some evidence of benefits over more complicated surgical procedures such as transposition. 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 patient has documented persistent numbness of the small and finger; however, the degree of loss of function related to this is not adequately defined. Recent conservative management has not been adequately documented. Qualified medical examination did not recommend further surgical intervention. The patient does not have evidence that her condition has worsened. There is no evidence of muscle wasting and EMG studies do not show muscle abnormality. The patient had undergone 2 previous surgical treatments related to ulnar neuropathy. Finally, submuscular transposition is not recommended from ACOEM: Quality studies are available on submuscular

transposition. Submuscular transposition has not been shown to be beneficial. This surgical option for this problem is high cost, invasive, and has side effects. Thus, submuscular transposition is not recommended. Thus, the left revision ulnar nerve decompression with muscle transposition is not medically necessary.