

Case Number:	CM13-0070467		
Date Assigned:	01/03/2014	Date of Injury:	12/28/2009
Decision Date:	07/03/2014	UR Denial Date:	12/04/2013
Priority:	Standard	Application Received:	12/24/2013

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/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:

This female has a date of injury of 1/1/09 to 12/28/09. She notes bilateral shoulder and hand pain as well as numbness and tingling of her hands that awaken her at night. She must shake her hands to relieve the symptoms. She wears wrist splints. Nerve conduction testing reviewed by [REDACTED] showed moderate bilateral carpal tunnel syndrome and mild left cubital tunnel syndrome. Decompression is planned.

IMR ISSUES, DECISIONS AND RATIONALES

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

CARPAL TUNNEL RELEASE: Overturned

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

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

Decision rationale: The carpal tunnel release is medically necessary. According to the ACOEM guidelines, Chapter 11, 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. 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." This patient has significant symptoms of carpal tunnel syndrome ("constant numbness and tingling of both wrists"), has persistent symptoms despite steroid injections, an exam consistent with carpal tunnel syndrome and positive electrodiagnostic studies for median nerve compression, described as moderate in the report. Per the ACOEM guidelines, carpal tunnel release is medically necessary.

CUBITAL TUNNEL SURGERY: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 240.

Decision rationale: According to the ACOEM guidelines, Chapter 10 page 240, "Surgery for ulnar nerve entrapment is indicated after establishing a firm diagnosis on the basis of clear clinical evidence and positive electrical studies that correlate with clinical findings. A decision to operate presupposes that a significant problem exists, as reflected in significant activity limitations due to the specific problem and that the patient has failed conservative care, including 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 elbow flexation while sleeping." The patient has mild cubital tunnel on nerve conduction testing and has not had a documented trial of medical management.

NSAIDS MEDICATION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-68.

Decision rationale: CA MTUS requires documentation of "Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects" for patients utilizing ongoing anti-inflammatory medication therapy. The patient has been approved for NSAIDS in the past. The records do not document the outcome of prior NSAID use as required by the MTUS.

CAPSAICIN 0.375%/MENTHOL10%/CAMPHOR 2.5%/TRAMADOL 20%-30 GM JAR & 240 GM JAR: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 71.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: Per the CA MTUS, topical analgesics are "Largely experimental in use, with few randomized controlled trials to determine efficacy or safety; primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The records do not document a trial of antidepressants and anticonvulsants.

FLUBIPROFEN 25%/DICLOFENAC10% 30 GM JAR & 240 GM JAR: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 71.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: Per the CA MTUS, topical analgesics are "Largely experimental in use, with few randomized controlled trials to determine efficacy or safety; primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The records do not document a trial of antidepressants and anticonvulsants.

COMPUTERIZED ROM AND MUSCLE TESTING: 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), Low Back.

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: The functional range of motion of the finger joints. Bain GI, Polites N, Higgs BG, Heptinstall RJ, McGrath AM. J Hand Surg Eur Vol. 2014 May 23.

Decision rationale: MTUS and ACOEM do not address the indications for computerized range of motion. In this case, the records do not provide a rationale for why standard range of motion testing as performed routinely by an MD or occupational therapist is not sufficient for documentation in this case. Computerized range of motion is not indicated for health reasons.