

Case Number:	CM14-0136711		
Date Assigned:	09/03/2014	Date of Injury:	10/16/2013
Decision Date:	09/24/2014	UR Denial Date:	08/05/2014
Priority:	Standard	Application Received:	08/25/2014

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. 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 45 year old female with a reported date of injury on 10/16/13 who requested authorization for left ulnar nerve release with possible transfer and endoscopic left carpal tunnel release. Since her injury, the patient had been treated for left shoulder and neck symptoms, as well as a left upper extremity radiculopathy. MRI examination of the neck noted abnormal findings at the C3-4, C4-5 and C5-6 levels. The patient is noted to have undergone acupuncture and physical therapy for treatment of left neck and shoulder pain. Documentation from 3/24/14 notes soreness of the left shoulder that occasionally tingles to the c-spine. The shoulder is improved with acupuncture. The patient is noted to be taking NSAIDs. Diagnoses note cervical spondylosis at C5-6, left shoulder impingement and left arm radiculopathy. The patient is to continue a home exercise program. Documentation from 4/14/14 notes the patient returned to regular duty at work. She still has some tingles, pain and discomfort of the c-spine and left shoulder. She is 80% better. Examination notes decreased left C8 sensation with 5/5 strength bilaterally. She is tolerating regular duty with mild residual neck and shoulder pain. She is overall improved. Documentation from 5/12/14 notes the patient with pain to the left shoulder that increases with range-of-motion and pain to the neck and left shoulder. The patient is noted to have cervical spondylosis C5-6 flare-up and left shoulder impingement. Recommendation was made for physical therapy of the c-spine. Physical therapy evaluation dated 5/16/14 notes the patient is experiencing symptoms of the left neck and shoulder. Treatment is documented. Physical therapy treatment dated 5/21/14 notes the patient is tolerating a home exercise program. Treatment of the neck is documented. Physical therapy treatment dated 6/11/14 notes left shoulder pain and neck stiffness. Treatment of the left shoulder and neck is documented. Physical therapy treatment dated 6/18/14 notes the patient's left arm went numb for 2 hours while at work. This resolved and he did not have any numbness on this day. Treatment of the left

shoulder and neck was documented. Physical therapy note dated 6/25/14 notes the patient with tingling in both hands and feet that is becoming more persistent. Treatment is noted. Documentation from 7/7/14 notes patient with continued neck and left shoulder pain. Numbness and tingling is noted of the left arm down to the left leg. Examination notes left elbow with positive Tinel's and mild hyperflexion, and left wrist with negative Tinel's and mild Phalen's test. C-spine is tender to palpation. Recommendation is made for electrodiagnostic studies and continued home exercise program. Electrodiagnostic studies from 7/16/14 note chronic bilateral C5 radiculopathy, left ulnar neuropathy across the elbow, mild bilateral median neuropathy at the wrist based on comparison studies, and suggestion of mild right ulnar neuropathy across the elbow. There is pain of the c-spine, left arm pain with numbness and tingling, and left shoulder pain. Examination notes tenderness of the C-spine, positive Tinel's at the left elbow, left wrist with positive Tinel's and Phalen's, and decreased sensation and motor in the median and ulnar nerve distribution. Diagnoses include C5-6 radiculopathy, left shoulder impingement, carpal tunnel syndrome and left cubital tunnel syndrome. Recommendations are for possible injection of the cervical spine, left ulnar nerve release with possible transfer and left carpal tunnel release. The patient is stated to have tried and failed splinting for the wrist and has failed non-operative therapy. Documentation from 8/22/14 notes surgery was denied and that the patient continues to complain of neck pain, left shoulder pain down to the left arm and numbness and tingling of the left upper extremity. There are no changes. Examination notes C-spine with positive Spurlings, increased left arm pain, left elbow with positive Tinel's, positive hyperflexion and decreased ulnar sensory, left wrist with positive Tinel's and Phalen's test, and left shoulder with impingement. Under the treatment plan, the patient is noted to have left upper extremity neurogenic pain and increased left radiculopathy. She has continued left cubital tunnel and carpal tunnel syndrome. She has failed night splinting, occupational therapy and medications and has positive electrodiagnostic studies and objective findings. Recommendations are made for pain management consultation and Celebrex. Continued recommendation is made for surgical intervention of the left wrist and elbow. Patient is to have a qualified medical evaluation (QME). Utilization review dated 8/5/14 did not certify the procedures. Reasoning given was that 'the report since the injury have never addressed the wrist or identified any wrist symptoms or exam findings until after the EMG/NCV and would not have allowed for any meaningful conservative care, splinting or a cortisone injection trial.' Guidelines are not strong in support for surgery for mild disease of the median nerve. There are no reports related to the left elbow ulnar entrapment until one visit prior to the EMG/NCV and again insufficient time for conservative management. Additionally, the electrical findings are mild and the data does not support early surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgery: Left Ulnar Nerve Release possible transfer: Upheld

Claims Administrator 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 / Cubital Tunnel.

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

Decision rationale: The patient is a 45 year old female with initial complaints of left shoulder pain and neck pain. During physical therapy treatment the patient complained of a change in her symptoms that was further evaluated from the note documented on 7/7/14. This was the first examination that noted a Tinel's sign of the left elbow consistent with ulnar neuropathy at the elbow. This was investigated with electrodiagnostic studies that suggested a left ulnar neuropathy at the elbow. This was further evaluated on 7/25/14 and 8/22/14 and noted no improvement in her symptoms. The patient has only been stated to have failed splinting and conservative treatment. 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. Based on these guidelines and the relatively recent diagnosis, the patient is not adequately documented to have failed conservative management. The physical therapy and acupuncture treatment that was documented was related to neck and shoulder complaints and not specific to the elbow and ulnar neuropathy. The patient has not been documented to have used elbow pads, changed her activity to remove opportunities to rest the elbow on the ulnar groove or to prevented prolonged elbow flexion while sleeping. The patient is not noted to have severe neuropathy such as muscle wasting and a time period of 3-6 months of conservative care has not been attempted prior to surgical recommendation. Thus, ulnar nerve release at the elbow should not be considered medically necessary at this point for this patient.

Left Endoscopic CTR possibly open at [REDACTED] : Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 270; 272-273.

Decision rationale: From ACOEM, 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 electro diagnostically 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. Mild CTS with normal electrodiagnostic studies (EDS) exists, but moderate or severe CTS with normal EDS is very rare. Positive EDS in asymptomatic individuals is not CTS. Studies have not shown portable nerve conduction devices to be effective diagnostic tools. Surgery will not relieve any symptoms from cervical radiculopathy (double crush syndrome). From page 272, Table 11-7, recommendations are made with respect to mild and moderate carpal tunnel syndrome. Injection of corticosteroids into carpal tunnel in mild or moderate cases of CTS after a trial of splinting and medication is recommended. The patient has not been considered for steroid injection. Further, the patient is noted to have evidence of cervical radiculopathy and 'surgery will not relieve any symptoms from cervical radiculopathy (double crush syndrome).' Finally, early surgical intervention for severe CTS confirmed by NCV may be indicated. The patient is not documented to have severe carpal tunnel syndrome and thus early surgical intervention is not indicated. In summary, the patient is documented to have a mild left carpal tunnel syndrome. It is not clear that the patient has undergone appropriate conservative management, including well-documented splinting and consideration for steroid injection. There has been an insufficient time interval for conservative management. Thus, early surgical intervention should not be considered medically necessary.

Pre-operative medical clearance: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 270; 272-273.

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

Post operative occupational therapy 2 x 3 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 270; 272-273.

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