

<b>Case Number:</b>	CM14-0152804		
<b>Date Assigned:</b>	09/23/2014	<b>Date of Injury:</b>	07/23/2012
<b>Decision Date:</b>	11/17/2014	<b>UR Denial Date:</b>	09/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2014

### 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 Orthopedic Surgery and is licensed to practice in California. 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 52 year old female who sustained an industrial injury on 7/23/2012. She underwent left carpal tunnel release, cubital tunnel release and excision of the left wrist ganglia on 9/30/2013. The prior peer review dated 9/8/2014 noncertified the requested surgery, left wrist injection, and postop PT. The extent of conservative care was not documented. The medical necessity of the requests were not established. According to the 3/4/2014 progress report, the patient complains of hypersensitivity over the cubital tunnel scar tissue. She has some tingling in the posterior aspect of her elbow. ROM is improving. She has slight keloid formation over this scar and slight hypoesthesia. She has good sensation of the hand, ulnar and median intrinsics work well. She is returned to work without restrictions. According to the 5/2/2014 progress report, the patient is seen for causalgia and neuroma of the medial and brachial cutaneous nerve of the left elbow. The assessment is that she has good relief of cubital and carpal tunnel syndromes with surgery. However, she has a neuroma and causalgia of the medial and brachial cutaneous nerve of the left elbow. This may improve over time. If it does not, she would require a neuroma excision of the medial antebrachial cutaneous nerve of the elbow. Follow up in 3 months. According to the progress report dated 8/26/2014, the patient is seen for causalgia and neuroma of the medial and brachial cutaneous nerve of the left elbow. She had insitu decompression over the elbow, open CTR, and excision of dorsal wrist ganglion on 9/30/2013. She has persistent posterior elbow numbness, tingling, and electrical shock sensation, despite course of Neurontin and TENS unit. She has wrist pain with gripping activities. Pertinent examination findings are normal ROM of the upper extremities, well-healed surgical scars at the left elbow and wrist, hypoesthesia and hyperesthesia in the distribution of the medial antebrachial cutaneous nerve, positive Tinel's percussion at the posterior elbow at the scar over the medial antebrachial cutaneous nerve, and slight tenderness of the wrist over the DRUJ. Left

wrist MRI 7/10/2013 showed synovitis, calcifications, and tear of the TFCC consistent with chondrocalcinosis and synovitis of ECU tendon. Left wrist x-rays were taken, and reportedly show neutral ulnar variance, significant osteopenia, normal carpal alignment no arthritis of the radiocarpal, midcarpal, distal radial or CMC joints. Assessment is persistent postoperative neuroma and causalgia symptoms of the medial antebrachial cutaneous nerve of the posterior elbow, status post ulnar nerve decompression. Wrist pain is probably secondary to pseudogout and a TFCC tear.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **NEUROLYSIS OF THE MEDIAL ANTECUBITAL CUTANEOUS NERVE OF THE DISTAL MEDIAL ARM AND ELBOW, NEUROMA EXCISION AND NEUROMA TRANSFER INTO THE SOFT TISSUE: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, HAND SURGERY

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 34-36.

**Decision rationale:** Referral for surgical consultation may be indicated for patients who have:- Significant limitations of activity for more than 3 months; - Failed to improve with exercise programs to increase range of motion and strength of the musculature around the elbow; or - Clear clinical and electrophysiologic or imaging evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. If surgery is a consideration, counseling regarding likely outcomes, risks, and benefits, and especially expectations is very important. The medical records do not provide a thorough and detailed recent treatment history as it pertains to this current complaint. There also lacks evidence to support clinically significant loss or limitation of function as to support a need for further surgical intervention at this time. Also, there does not appear to be evidence of a clear surgical lesion demonstrated on imaging. Given these factors, the medical necessity of the proposed surgical intervention has not been established. Therefore the request is not medically necessary.

#### **POST OPERATIVE PHYSICAL THERAPY 2X A WEEK FOR 6 WEEKS: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 16-17.

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

