MAXIMUS Federal Services

Case Number:	CM14-0179701		
Date Assigned:	11/04/2014	Date of Injury:	10/12/2006
Decision Date:	12/09/2014	UR Denial Date:	10/02/2014
Priority:	Standard	Application Received:	10/29/2014

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, has a subspecialty in Hand 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 injured worker is a 57-year-old female who reported injuries of unspecified mechanism on 10/12/2006. On 09/25/2014, her diagnoses included bilateral cubital tunnel syndrome, electrodiagnostically positive; recurrent bilateral carpal tunnel syndrome, electrodiagnostically positive, previously released; and fibromyalgia, nonindustrial. Her complaints included persistent pain, numbness, and tingling of her bilateral upper extremities, worse on the left side. The numbness and tingling localized into the ring and small fingers. There were electric shock-like sensations in the medial aspect of both elbows radiating down into the hands. She had a positive Tinel's right ulnar nerve at the elbow. She had a positive bilateral elbow flexion test with worsening numbness and tingling into the ulnar nerve distribution. She had positive bilateral Phalen's tests. It was noted that an EMG/NCV on 06/04/2014 revealed bilateral carpal tunnel syndrome with prolongation of the distal latency of median and sensory nerves; bilateral carpal tunnel syndrome, left worse than right. It was noted she had temporary improvement with therapy. The types, amounts, modalities, and date of therapy were not submitted for review. It was noted that she had failed to relieve her symptoms with medication. Her medications included Vicodin, Soma, and Zantac of unspecified dosages. It was also noted that she failed to relive her symptoms with activity modification and splinting on both elbow and wrist. There was no rationale or Request for Authorization included in this injured worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left ulnar nerve decompression at the elbow with possible transposition and revision left carpal tunnel release with possible hypothenar flap transfer: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 45-46.

Decision rationale: The California ACOEM Guidelines note that 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, work station changes are applicable, and avoiding nerve irritation at night by preventing prolonged elbow flexion while sleeping. The clinical information does support that the injured worker is significantly symptomatic although physical therapy, medications, splinting of both elbows has been attempted. However, the clinical documentation did not contain an independent evaluation of the electrodiagnostic study performed on 06/04/2014. Furthermore, the request does not specifically identify the technique for transposition of the nerve. As submuscular transposition is not supported by the ACOEM guidelines, the appropriateness of the request itself cannot be determined. Therefore, this request for Left ulnar nerve decompression at the elbow with possible transposition and revision left carpal tunnel release with possible hypothenar flap transfer is not medically necessary.