

Case Number:	CM14-0024107		
Date Assigned:	02/28/2014	Date of Injury:	11/22/2010
Decision Date:	06/27/2014	UR Denial Date:	12/18/2013
Priority:	Standard	Application Received:	01/16/2014

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:

This 59-year-old female [REDACTED] sustained an industrial injury 11/22/10 due to repetitive work duties. The 6/18/13 EMG/Nerve conduction study conclusion documented moderate bilateral carpal tunnel syndrome and no evidence of a cervical radiculopathy. The remainder of the studies were unremarkable. The 12/18/13 utilization review of the request for bilateral carpal tunnel release with ulnar decompression surgery modified the request and certified the bilateral carpal tunnel releases. The ulnar decompression surgery was denied as there was no evidence either clinically or by nerve conduction testing to support ulnar nerve entrapment or neuropathy at the elbow. The 2/3/14 surgical report cited a three year history of bilateral hand numbness and tingling intermittently in the ulnar and median nerve distributions, and bilateral forearm and wrist pain. Paresthesias woke her at night, left greater than right, and more commonly in the median than ulnar distribution. Diffuse bilateral forearm pain was worsened with repetitive activity. Physical exam findings documented positive Tinel's and Phalen's, and positive compression bilaterally with thumb abductor weakness, no atrophy. There was tenderness with positive Tinel's and flexed elbow compression test with no first dorsal interossei weakness. There was tenderness over the bilateral radial tunnels with resisted wrist extension, middle finger extension, and forearm supination. There was bilateral ulnocarpal joint tenderness with positive ulnocarpal grind. The diagnosis was bilateral carpal tunnel syndrome, cubital tunnel syndrome, radial tunnel syndrome, and ulnocarpal impaction. The patient had failed comprehensive conservative treatment. The treatment plan recommended staged bilateral carpal tunnel releases and cubital tunnel releases beginning with the left side.

IMR ISSUES, DECISIONS AND RATIONALES

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

BILATERAL CARPAL TUNNEL RELEASE WITH ULNAR 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 10 Elbow Disorders (Revised 2007) Page(s): 36-37. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal tunnel syndrome, Carpal tunnel release surgery (CTR)

Decision rationale: Under consideration is a request for bilateral carpal tunnel release with ulnar decompression. The California MTUS guidelines do not provide recommendations for carpal tunnel release surgery for chronic injuries. The Official Disability Guidelines for carpal tunnel release typically require symptoms and exam findings consistent with carpal tunnel syndrome, and initial conservative treatment including three of the following: activity modification, night wrist splint, non-prescription analgesia, home exercise training, and/or successful corticosteroid injection trial. Positive electrodiagnostic evidence of carpal tunnel syndrome is required. The California MTUS elbow guidelines state 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. Surgery is recommended in the form of simple decompression for patients with chronic ulnar neuropathy at the elbow who have positive electrodiagnostic studies, objective evidence of loss of function, and lack of improvement with 3 to 6 months of comprehensive conservative treatment. Guideline criteria have not been met for the ulnar decompression surgery. There is no current electrodiagnostic evidence of ulnar neuropathy; the 6/18/13 EMG/NCV findings documented moderate bilateral carpal tunnel syndrome, no ulnar neuropathy. Guideline criteria have been met for carpal tunnel release. The 12/18/13 utilization review modified the request for bilateral carpal tunnel release with ulnar decompression and certified the bilateral carpal tunnel releases. Therefore, this request for bilateral carpal tunnel release with ulnar decompression is not medically necessary.