Case Number:	CM14-0054449		
Date Assigned:	08/08/2014	**Date of Injury:**	11/15/2010
Decision Date:	09/11/2014	**UR Denial Date:**	04/10/2014
Priority:	Standard	**Application Received:**	04/23/2014

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 is a 39-year-old female who sustained a vocational injury on 04/10/14 working as a clerical supervisor. The claimant underwent an MRI of the right wrist on 12/29/11 which showed a cyst versus a pseudocyst related to the palmar aspect of the capitate/trapezoid region. There are no fractures, dislocations or osteonecrosis. There is possible but not definite triangular fibroid cartilage tear and/or loss of the integrity of the scapholunate and lunotriquetral ligaments. An MRI was also performed of the right elbow on the same day which showed fluid in the elbow joint olecranon fossa. There were no fractures or dislocations. There were no specific focal signs for internal derangement. There were no abnormalities noted. EMG nerve conduction studies are found in the documentation submitted for review; however, the individual's name on the report as well as the age and date of birth do not coincide with the claimant's same name or date of birth and subsequently cannot be used to provide a recommendation for medical necessity. The claimant's current working diagnosis is of a right cubital/carpal tunnel syndrome and right lateral epicondylitis. The most recent office note available for review is from 04/02/14 and is noted to be handwritten and essentially illegible and subsequently cannot be used as documentation which would be of any value to making a determination. Most legible office note available for review was from 12/18/13 at which time it was noted that the claimant had persistent pain in the right upper extremity with numbness and tingling. She was noted to have been psychologically cleared for surgical intervention. She had tenderness at the right olecranon fossa and volar aspect of the wrist. She had positive Tinel's at the elbow and positive Tinel's and Phalen's at the wrist. She had pain with terminal flexion and weak grip. She had dysesthesias of the digits. Previous utilization review determination noted that the claimant had EMG nerve conduction studies of the upper extremities on 10/25/11 which were within normal limits and showed no evidence of carpal tunnel syndrome or cubital tunnel syndrome. There is no evidence

of other peripheral nerve entrapment neuropathy or peripheral neuropathy. There was irritation of the right median nerve and the ulnar nerve at the elbow. Conservative treatment to date includes medications. The current request is for right carpal tunnel release and right cubital tunnel release with ulnar nerve transposition.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Carpal Tunnel Release, Right Cubital Tunnel Release with Ulnar Nerve Transposition: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); elbow chapter Surgery for cubital tunnel syndrome (ulnar nerve entrapment) the elbow. Surgery for ulnar neuropathy at the elbow is effective at least two-thirds of the time. The outcomes of simple decompression (SD) and anterior subcutaneous transposition (AST) are equivalent, except for the complication rate, which is 31% in AST. Because the intervention is simpler and associated with fewer complications, SD is generally advised. (Bartels, 2005) (Asamoto, 2005) (Lund, 2006) (Nabhan, 2007) Although clinically equally effective, simple decompression was associated with lower cost than anterior subcutaneous transposition for the treatment of ulnar neuropathy at the elbow. The main difference was in the costs related to sick leave, which is significantly shorter for simple decompression. (Bartels2, 2005) (Nabhan, 2005) Simple decompression may offer excellent intermediate and long-term relief of symptoms. Less complete relief of symptoms following ulnar nerve decompression may be related to unrecognized carpal tunnel syndrome or weight gain. (Nathan, 2005) Medial epicondylectomy for persons with cubital tunnel syndrome was superior to anterior transposition in relieving pain and in improving global outcome scores. Patients whose cubital tunnel syndrome is caused by an acute trauma have better outcomes after surgical treatment than patients with cubital tunnel syndrome from other causes. (AHRQ, 2002) Partial medial epicondylectomy seems to be safe and reliable for treatment of cubital compression neuropathy at the elbow. (Efstathopoulos, 2006) One study reviewed the results of two surgical methods for treating cubital tunnel syndrome. From 1994 to 2001, minimal medial epicondylectomy was performed on 22 elbows, and anterior subcutaneous transposition of the ulnar nerve was done on 34 elbows. In the group treated by medial epicondylectomy, 9 of the results (41%) were excellent, 10 (45%) were good, 2 (9%) were fair, and 1 result (5%) was poor. In the group treated by anterior subcutaneous transposition of ulnar nerve, 14 of the results (41%) were excellent, 13 (38%) were good, 6 (18%) were fair, and 1 result (3%) was poor. No significant difference was found between the 2 groups ($P < .05$). (Baek, 2005) (Greenwald, 2006) Age at surgery, duration of cubital tunnel syndrome, preoperative severity, and clinical symptom score and motor nerve conduction velocity in the early postoperative stage (one month after surgery) were found to be important prognostic factors of the syndrome. (Yamamoto, 2006). Simple decompression vs anterior transposition: Transposition may only be required if the ulnar nerve subluxes on ROM of the elbow. Otherwise simple decompression is recommended. (Heithoff, 1999) (Posner, 1998) (Bartels, 2005) (Elhassan, 2007) Irrespective of the surgical method, roughly 90% of patients are satisfied with surgical treatment of the ulnar nerve entrapment. However, one specific group of patients (people with habitual ulnar luxation or subluxation of the ulnar nerve) experienced a distinctly better result when treated

by anterior transposition than by simple decompression, so simple decompression of the ulnar nerve can be recommended in all patients without cubital (sub)luxation of the nerve, whereas people with a tendency of cubital (sub)luxation of the ulnar nerve should be treated by submuscular anterior transposition. (Bimmler, 1996) In this study, both simple decompression and anterior transposition resulted in improvement in over 80% of cases, but a higher percentage of full recovery was seen in the cases treated by simple decompression. (Chan, 1980) The results of simple decompression of the ulnar nerve are similar to transposition, so the former simpler method is recommended as the standard procedure. (Lugneg 1982) The advantages of simple decompression make it the.

Decision rationale: California MTUS/ACOEM Guidelines have been referenced. California MTUS/ACOEM Guidelines note that prior to considering surgical intervention for a cubital tunnel and carpal tunnel release documentation should establish that claimant's have attempted, failed and exhausted conservative treatment including work site modifications. In addition, there should be clear clinical and specific study evidence of a lesion that has been shown to benefit both in the short and long term for surgical intervention. Currently documentation presented for review fails to establish that there has been an attempt and failure of a reasonable course of conservative treatment and documentation also fails to establish that there is electrophysiologic evidence of carpal tunnel and cubital tunnel syndrome which may be amenable by surgical intervention. Furthermore, based on the documentation presented for review and in accordance with California MTUS/ACOEM and Official Disability Guidelines, the request for the right cubital tunnel and carpal tunnel release following a nerve transposition cannot be considered medically necessary.

Post-Operative Rehab and Gentle Range of Motion Exercises to the Right Wrist 3 Times a Week for 4 Weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Re Evaluation for Continued Therapy Post- 12 Visits/Sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: Surgical intervention has been deemed not medically necessary, and subsequently the request for postop rehab with gentle range of motion to the right wrist, a reevaluation for continued therapy after twelve sessions, a wrist sling and medical clearance cannot be considered medically necessary.

Durable Medical Equipment (DME) -Wrist Sling: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Forearm, Wrist and Hand chapter & Elbow chapterImmobilization (treatment)Not recommended as a primary treatment for undisplaced fractures or sprains, but recommended for displaced fractures. See Splints & Casting. Immobilization and rest appear to be overused as treatment. Early mobilization benefits include earlier return to work; decreased pain, swelling, and stiffness; and a greater preserved range of joint motion, with no increased complications. (Nash, 2004) (Liow, 2002) Early physical therapy, without immobilization, may be sufficient for some types of undisplaced fractures. It is unclear whether operative intervention, even for specific fracture types, will produce consistently better long-term outcomes. There was some evidence that immediate physical therapy, without routine immobilization, compared with that delayed until after three weeks immobilization resulted in less pain and both faster and potentially better recovery in patients with undisplaced two-part fractures. Similarly, there was evidence that mobilization at one week instead of three weeks alleviated pain in the short term without compromising long-term outcome. (Handoll-Cochrane, 2003) (Handoll2-Cochrane, 2003)Elbow chapterImmobilization (treatment)Not recommended as a primary treatment. Immobilization and rest appear to be overused as treatment. Early mobilization benefits include earlier return to work; decreased pain, swelling, and stiffness; and a greater preserved range of joint motion, with no increased complications. (Nash, 2004) (Liow, 2002) Early physical therapy, without immobilization, may be sufficient for some types of undisplaced fractures. It is unclear whether operative intervention, even for specific fracture types, will produce consistently better long-term outcomes. There was some evidence that 'immediate' physical therapy, without routine immobilization, compared with that delayed until after three weeks immobilization resulted in less pain and both faster and potentially better recovery in patients with undisplaced two-part fractures. Similarly, there was evidence that mobilization at one week instead of three weeks alleviated pain in the short term without compromising long-term outcome. (Handoll-Cochrane, 2003) (Handoll2-Cochrane, 2003).

Decision rationale: Surgical intervention has been deemed not medically necessary, and subsequently the request for postop rehab with gentle range of motion to the right wrist, a reevaluation for continued therapy after twelve sessions, a wrist sling and medical clearance cannot be considered medically necessary.

Medical Clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) ACOEM Chapter 7, page 127.

Decision rationale: Surgical intervention has been deemed not medically necessary, and subsequently the request for postop rehab with gentle range of motion to the right wrist, a reevaluation for continued therapy after twelve sessions, a wrist sling and medical clearance cannot be considered medically necessary.