

Case Number:	CM14-0057700		
Date Assigned:	07/09/2014	Date of Injury:	09/08/2000
Decision Date:	09/25/2014	UR Denial Date:	04/02/2014
Priority:	Standard	Application Received:	04/28/2014

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 64-year-old male senior equipment specialist sustained an industrial injury on 9/8/00, relative to a fall. The patient underwent right carpal tunnel release on 9/27/05 and revision carpal tunnel release on 9/27/07 and 11/15/12. Past surgical history was positive for 5 right shoulder surgeries, left carpal tunnel release, and ulnar nerve decompressions at the wrists bilaterally. The 2/11/14 bilateral upper extremity EMG/NCV report documented abnormal right median nerve conduction and related EMG findings in the upper extremity. There was no evidence of chronic, inactive denervation involving the right median nerve supply of the right abductor pollicis brevis. There were no other acute or chronic neuropathic findings noted. The 2/24/14 right wrist MRI impression documented advanced arthritic change of the wrist with marked capsular synovitis and thickening and osteoarthritis of the radiocarpal, ulnar carpal and distal radial ulnar joint. There was a chronic tear of the scapholunate ligament. There was associated capitates migration and developing SLAC wrist. There was tenosynovitis of the flexor and extensor compartments with high-grade extensor carpi ulnaris tendinopathy at the ulnar styloid level. There was a large complex cyst of the volar aspect of the wrist arising near the mid carpal row and resulting in mass effect upon the flexor tendons within the carpal tunnel. The cyst contained a large amount of debris and appeared related to the patient's underlying arthritis. Given the constellation of findings, clinical correlation was recommended for underlying inflammatory arthritis, most commonly rheumatoid, with superimposed osteoarthritis. The 3/26/14 treating physician report cited right wrist pain with occasional numbness and tingling. Right upper extremity exam documented small finger flexed 25 degrees at the proximal interphalangeal joints and wrist flexion/extension 35 degrees. The patient was very tender to palpation over the right carpal tunnel and exquisitely tender at the right midline volar forearm scar. There was decreased 2.83 monofilament at the thumb and index finger and Tinell's, Durkan's, and Phalen's were positive at

the wrist. The treatment plan recommended revision of scar, exploration of right median and ulnar nerve at the wrist, with possible revision of median and ulnar nerve release at the wrist with hypothenar fat flap to be done with authorized excision of the large palmar cyst at the wrist. The 4/2/14 utilization review denied the request for right wrist surgery as there was no indication for ulnar nerve decompression given the lack of physical findings and confirmatory neurodiagnostic studies. There was a lack of significant numbness and paresthesia relative to carpal tunnel syndrome and median nerve conduction does not always return to normal after carpal tunnel release. There were equivocal exam findings relative to carpal tunnel syndrome. This was the fourth surgical procedure for right carpal tunnel syndrome and given the findings of inflammatory arthritis, rheumatoid arthritis should be ruled-out prior to proceeding with surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Revision of scar, exploration of right median and ulnar nerve at the wrist, with possible revision of median and ulnar nerve release at the wrist with hypothenar fat flap to be done with authorized excision of the large palmar cyst at the wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Indications for Surgery- Carpal Tunnel Release.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270, 98.

Decision rationale: The ACOEM Guidelines state that carpal tunnel syndrome should be proved by positive findings on clinical exam and the diagnosis should be supported by nerve conduction tests before surgery is undertaken. Criteria include failure to respond to conservative management, including worksite modification, splinting, medications and positive corticosteroid injection. The ACOEM Guidelines recommend electrodiagnostic testing to confirm clinical suspicion of ulnar nerve entrapment at the wrist. Guidelines recommend surgical decompression for subacute or chronic ulnar nerve compression at wrist after failure of non-operative treatment if space-occupying lesions are present. Guideline criteria have not been met. There are no clinical exam or electrodiagnostic findings documented that evidence ulnar nerve compression at the wrist. Clinical correlation and further evaluation of underlying inflammatory arthritis has been recommended but is not evidenced. Therefore, this request is not medically necessary.