

Case Number:	CM14-0067856		
Date Assigned:	07/11/2014	Date of Injury:	07/28/2007
Decision Date:	08/11/2014	UR Denial Date:	05/05/2014
Priority:	Standard	Application Received:	05/12/2014

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 Orthopaedic 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 44-year-old female sustained an industrial injury on 7/27/07. The mechanism of injury was not documented. The 7/23/12 bilateral upper extremity EMG/NCV impression documented mild right median neuropathy at the wrist and bilateral C8 dorsal ramiopathy. The 7/23/12 cervical MRI impression documented a C5/6 disc protrusion flattening the anterior aspect of the spinal cord and mild central canal stenosis. There was congenitally narrowing of the spinal canal from C4 to C6 superimposed on multilevel degenerative changes. The patient underwent right carpal tunnel release on 8/27/13 and left carpal tunnel release on 10/8/13. The 12/11/13 treating physician report indicated the patient had done well post-operatively. There was residual right small finger numbness and tingling which was present before the carpal tunnel releases. Tinel's was positive at the cubital tunnel and ulna tunnel, right greater than left. An elbow sleeve was recommended to keep the elbow extended at night. A 12/17/13 request for right cubital tunnel release and ulnar tunnel release with associated services/durable medical equipment was noted. The 4/21/14 treating physician report cited grade 9/10 right cervical pain and spasms, and bilateral 4th and 5th digit tingling, right greater than left, that originated from the medial elbows. The bilateral first extensor thumbs were moderately tender. Symptoms worsened with repetitive hand activity. The patient occasionally dropped objects. Tramadol and Gabapentin had been most helpful. Bilateral wrist injections at the last visit provided decreased tenderness over the scar areas. Physical exam documented moderate cervicothoracic tenderness with focal nerve pain over the brachial plexus. Right upper extremity exam documented positive wrist compression sign, bilateral palmar scar hyperalgesia, moderate bilateral flexor/extensor forearm spasticity, and decreased sensibility over the 4th and 5th digits bilaterally. The diagnosis was cervical disc injury, bilateral lateral and medial epicondylitis, bilateral thoracic outlet syndrome, and bilateral ulnar neuritis. The treatment plan recommended referral to hand surgeon and

orthopedic spine specialist. The 5/5/14 utilization review denied the request for right cubital tunnel release and ulnar tunnel release as there was no positive electrodiagnostic evidence to confirm ulnar neuropathy at the wrist or elbow. There was also no documentation of failure of conservative treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre-operative History and Physical: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation.

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

Post-operative Right hand physical therapy 2 times 6: 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.

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

Right elbow wrist hand Orthosis: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272.

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

Right Cubital Tunnel Release and Ulnar Tunnel Release: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines 2nd Ed., Elbow Complaints Chapter (Revised 2007), and table 5.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 36-38.

Decision rationale: The California MTUS 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. 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, workstation changes (if applicable), and avoiding nerve irritation at night by preventing prolonged elbow flexion while sleeping. Absent findings of severe neuropathy such as muscle wasting, at least 3-6 months of conservative care should precede a decision to operate. Guideline criteria have not been met. There is no electrodiagnostic evidence of ulnar neuropathy. There is potential diagnostic overlap between cervical and upper extremity neuropathies, with electrodiagnostic report of bilateral C8 dorsal ramiopathy and current brachial plexus provocative testing. There is no detailed documentation that recent guideline-recommended comprehensive conservative treatment had been tried and failed. Therefore, this request for right cubital tunnel and ulnar tunnel release is not medically necessary.