

Case Number:	CM14-0091552		
Date Assigned:	07/25/2014	Date of Injury:	12/05/2009
Decision Date:	08/28/2014	UR Denial Date:	05/22/2014
Priority:	Standard	Application Received:	06/16/2014

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 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 45-year-old female sustained an industrial injury on 12/5/09, relative to moving heavy equipment. Past surgical history was positive for right carpal tunnel release on 8/19/11. The 3/1/13 bilateral upper and low back electrodiagnostic revealed evidence of peripheral neuropathy including bilateral median sensory and left median motor abnormality. Findings included bilateral ulnar nerve entrapment across the elbow and Guyon's canal. The 4/30/14 treating physician report cited multiple complaints including neck, back, bilateral shoulder, and bilateral upper extremity pain. Electrodiagnostic test results from 4/11/13 were unknown. The patient complained of bilateral ring and small finger numbness, worse on the left. She tried to sleep with her elbows extended at night. The physical exam documented full left wrist range of motion with positive carpal tunnel compression test but negative Tinel's. The elbow range of motion was 0-140 with positive Tinel's over the ulnar nerve behind the medial epicondyle. The treatment plan recommended left carpal and cubital tunnel surgery. The 5/22/14 utilization review denied the request for left carpal and cubital tunnel release as the required surgical criteria were not reported. The 6/9/14 orthopedic progress report indicated the patient's left carpal tunnel symptoms resolved following a cortisone injection on 4/30/14 and use of a wrist brace. There was occasional tingling in the left ring and small finger, especially when reaching overhead. A cervical epidural steroid injection two weeks prior improved her neck pain. The physical exam documented left elbow range of motion 0-140 degrees with no tenderness over the medial or lateral epicondyle or olecranon process. Tinel's sign was positive over the ulnar nerve behind the medial epicondyle. Left wrist range of motion was full. Tinel's was negative over the carpal tunnel, but compression test was positive. The diagnosis was resolved left carpal tunnel syndrome and left cubital tunnel syndrome. Discussion of continued conservative treatment was noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Carpal/Cubital Tunnel Release: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 36-37, 270.

Decision rationale: The California MTUS 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. The 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. The 6/9/14 report indicated that the patient's left carpal tunnel syndrome resolved following cortisone injection on 4/30/14. There is no detailed documentation that recent comprehensive guideline recommended conservative treatment directed to the left elbow had been tried and failed. Therefore, this request for left carpal and cubital tunnel release is not medically necessary.