

Case Number:	CM14-0098070		
Date Assigned:	07/28/2014	Date of Injury:	06/15/2011
Decision Date:	08/29/2014	UR Denial Date:	06/18/2014
Priority:	Standard	Application Received:	06/26/2014

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 40-year-old female receptionist sustained an industrial injury on 6/15/11, relative to repetitive work duties. The patient was status post right carpal tunnel release and ulnar nerve decompression on 6/14/12. Past medical history was positive for hypertension, diabetes, and current smoking. The 1/22/14 left upper extremity EMG revealed normal findings. The 3/18/14 left elbow MRI showed normal findings. The 3/20/14 left wrist MRI revealed small distal radial ulnar effusion and small focus subacromial marrow edema at the proximal edge of the trapezium. The 6/11/14 treating physician report cited gradually worsening left upper extremity pain and paresthesia. She received a steroid injection into the left carpal tunnel with transient relief of her symptoms. She had used wrist and elbow splints intermittently for 3 months with minimal to no improvement. Frequent nocturnal awakening, decreased sensation to soft touch, and upper extremity weakness and dropping things were reported. Left upper extremity physical exam documented normal range of motion, no tenderness, normal joint stability, 4/5 thumb abduction weakness, and otherwise 5/5 strength. There was slightly decreased sensation over the left thumb and long fingers. Tinel's was positive at the carpal tunnel and cubital tunnel on the left. Semmes-Weinstein monofilament testing was 2.83 over the left thumb, index, ring and small fingers, and 3.61 over the left long finger. Phalen's test was positive for paresthesias in a typical median nerve distribution. Elbow flexion test was positive for paresthesias in the left ring and small fingers. The patient had failed conservative treatment with continued difficulty performing home and work activities. Records indicated a consistent presentation of grade 7-10/10 pain regardless of treatment with continued attempts to remain at work. The 6/18/14 utilization review denied the left carpal tunnel release and ulnar nerve decompression and associated requests. The surgeries were denied as there was no electrodiagnostic evidence of carpal tunnel syndrome or ulnar neuropathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left open carpal tunnel release: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265, 270. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome.

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

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. The Official Disability Guidelines provide clinical indications for carpal tunnel release that include specific symptoms (abnormal Katz hand diagram scores, nocturnal symptoms, and/or Flick Sign), physical exam findings (compression test, monofilament test, Phalen's sign, Tinel's sign, decreased 2-point discrimination, and/or mild thenar weakness), conservative treatment (activity modification, night wrist splint, non-prescription analgesia, home exercise training), successful corticosteroid injection trial, and positive electrodiagnostic testing. This patient has met all guideline criteria but for positive electrodiagnostic testing. She reported worsening symptoms of pain and numbness with significant functional difficulty in activities of daily living and work activities. She has failed all guideline-recommended comprehensive conservative treatment. Therefore, this request for Left Open Carpal Tunnel Release is medically necessary.

Labs (CBC, BMP, EKG, Chest x-ray): Overturned

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: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. Guideline criteria have been met for the requested pre-operative screening tests. This 40-year-old female is a diabetic and smoker with known hypertension. Middle-aged females have known occult increased medical/cardiac risk factors.

Given these clinical indications, this request for labs (CBC, BMP, EKG, and Chest X-Ray) is medically necessary.

12 Post-op physical therapy sessions for the left wrist and left elbow: Overturned

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): 15-17.

Decision rationale: The California Post-Surgical Treatment Guidelines for surgical treatment of carpal tunnel syndrome suggest a general course of up to 8 post-operative visits over 3-5 weeks during the 3-month post-surgical treatment period. Guidelines for surgical treatment of cubital tunnel syndrome suggest a general course of 20 post-operative visits over 10 weeks during the 6-month post-surgical treatment period. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. Given the surgical requests, this request for 12 Post-Operative Physical Therapy sessions for the Left Wrist and Elbow is medically necessary.

Left ulnar nerve decompression at the cubital tunnel, possible ulnar nerve transposition: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 37. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 35-36.

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. EMG/NCV testing did not evidence ulnar neuropathy. There is documentation that this patient has been afforded guideline-recommended conservative treatment over the past year with no improvement. The patient has clinical exam findings consistent with ulnar neuropathy at the cubital tunnel with reported worsening. There is functional difficulty noted in activities of daily living and at work. The patient has been maintained at modified duty with fairly stable grade 7-

10/10 pain. Therefore, this request for Left Ulnar Nerve Decompression at the Cubital Tunnel, Possible Ulnar Nerve Transposition is medically necessary.