

Case Number:	CM14-0213628		
Date Assigned:	12/31/2014	Date of Injury:	02/10/2014
Decision Date:	03/04/2015	UR Denial Date:	12/17/2014
Priority:	Standard	Application Received:	12/19/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Orthopedic Surgery

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

36 year old female claimant with an industrial injury dated 02/10/14. The patient is status post right carpal tunnel release as of 06/06/14, along with 16 physical therapy sessions. Exam note 08/13/14 stats the patient is status post nerve testing in which provides evidence of severe bilateral carpal tunnel syndrome and cubital tunnel syndrome. There is evidence that the patient has symptoms worse on the right than the left with volar wrist pain, medial elbow pain, ulnar wrist pain, and numbness running into the fingers including the ulnar distribution, radial forearm pain, and posterior trapezius pain. Exam Tinel's, carpal compression, and Phalen's test are all noted as positive bilaterally on the right worse than left. Diagnosis is noted as a sprain of the wrist, tenosynovitis of the hand/wrist/neck, carpal tunnel syndrome, and ulnar nerve lesion. Treatment includes a right submuscular ulnar nerve transposition.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left carpal tunnel release (CTR) and Submuscular Ulnar Nerve transposition (SMUNT):
Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow, Surgery for cubital tunnel

Decision rationale: Per the CA MTUS/ACOEM guidelines, Chapter 11 Forearm, Wrist and Hand Complaints page 270, Electrodiagnostic testing is required to eval for carpal tunnel and stratify success in carpal tunnel release. In addition, the guidelines recommend splinting and medications as well as a cortisone injection to help facilitate diagnosis. In this case there is lack of evidence in the records from 8/13/14 of failed bracing or injections in the records. Therefore the determination is for non-certification. CA MTUS/ACOEM is silent on the issue of surgery for cubital tunnel syndrome. According to the ODG, Elbow section, Surgery for cubital tunnel syndrome, indications include exercise, activity modification, medications and elbow pad and or night splint for a 3-month trial period. In this case there is insufficient evidence in the records that the claimant has satisfied these criteria in the exam note from 8/13/14. Therefore the determination is for non-certification.

Post -op physical therapy for eight (8) sessions: Upheld

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

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.

Outpatient physical therapy (PT) to the right arm/hand two (2) times a week for four (4) weeks: Upheld

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

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.