

<b>Case Number:</b>	CM15-0010211		
<b>Date Assigned:</b>	02/24/2015	<b>Date of Injury:</b>	06/15/2011
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	12/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/16/2015

### 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:

The injured worker is a 53 year old, female patient, who sustained an industrial injury on 06/15/2011. Electric nerve conduction study performed 12/09/2014 revealed bilateral median motor distal latency is prolonged. Left ulnar motor distal latency is prolonged, right is normal. Left ulnar sensory amplitude is decreased, right is normal; bilateral median sensory distal latency is prolonged. Right median/radial sensory comparison to the thumb prolonged, left is normal. Bilateral median F-wave latencies are normal. Bilateral ulnar F-wave latencies are normal. Needle myelograph study is abnormal with chronic neurogenic motor units and decreased recruitment in left FDI muscle. Exam note 12/2/14 demonstrates complaints of radiation to the shoulders, left forearm and wrist. Pain is noted with cervical range of motion. No documentation is noted of conservative care for radiating pain in the upper extremities. Bilateral triceps were also abnormal with chronic neurogenic motor units. The impression noted bilateral median neuropathy at the wrist CTS, moderate severity. Left ulnar neuropathy at the wrist and abnormal EMG in a pattern consistent with chronic bilateral C7-8 radiculopathy. A request was made for left anterior ulnar nerve transplantation; left carpal tunnel release, outpatient; pre-operative clearance; Zanaflex 2MG #60; continuous cold therapy until 14 day rental Pro-Sling durable medical equipment; and 12 post-operative visits. On 01/16/2015, Utilization Review non-certified the request noting the CA MTUS, Forearm, Wrist and Hand Complaints Chapter, Ulnar nerve surgery, and ACOEM Elbow Disorders were cited. The injured worker submitted an application for independent medical review of services requested.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Left anterior ulnar nerve transplantation:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Elbow, Surgery for cubital tunnel release.

**Decision rationale:** 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 exam note of 12/2/14 that the claimant has satisfied these criteria. Therefore the determination is for non-certification.

### **Left carpal tunnel release outpatient:** Upheld

**Claims Administrator 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).

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

**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 12/2/14 of failed bracing or injections in the records. Therefore the determination is for non-certification.

### **Associated service: Pre-operative clearance by an internist:** 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 Official Disability Guidelines, Low Back, Preoperative testing.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated service: Zanaflex 2mg #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Zanaflex Page(s): 66.

**Decision rationale:** Per the CA MTUS/Chronic Pain Treatment Guidelines, page 66, Zanaflex is appropriate for chronic myofascial pain syndrome and is approved for spasticity. In this case there is no objective evidence in the exam note from 12/2/14 supporting spasticity and no evidence of chronic myofascial pain syndrome or fibromyalgia. Therefore the determination is for non-certification.

**Associated service: Surgi Stim multi modality stimulator 14 day rental: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-119.

**Decision rationale:** Regarding the Interferential Current Stimulation (ICS), the California MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation, pages 118-119 state, Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. As there is insufficient medical evidence regarding use in this clinical scenario from the exam note of 12/2/14. Therefore, the determination is for non-certification.

**Associated service: Continuous cold therapy fourteen day rental: 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 Official Disability Guidelines, Elbow, Cryotherapy.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated service: Pro sling: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated service: Twelve post operative visits:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.