

<b>Case Number:</b>	CM15-0189543		
<b>Date Assigned:</b>	10/01/2015	<b>Date of Injury:</b>	07/16/2009
<b>Decision Date:</b>	11/16/2015	<b>UR Denial Date:</b>	09/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2015

### 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, Hand Surgery, Sports Medicine

### 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 31 year old female who sustained an industrial injury 07-16-09. A review of the medical records reveals the injured worker is undergoing treatment for cervical spine disc bulge, lumbar spine disc rupture, bilateral shoulder and right elbow strain, left elbow internal derangement, left carpal tunnel syndrome, status post right carpal tunnel surgery, and other problems unrelated to current evaluation. Medical records (08-12-15) reveal the injured worker complains of pain in the neck, lower back, right shoulder-arm, left shoulder, bilateral elbows and forearms, and bilateral hands and wrists. The physical exam (08-12-15) reveals light touch sensation in the right mid anterior thigh, right lateral calf, and right labral ankle are all diminished. Prior treatment includes right carpal tunnel release. The treating provider does not report any diagnostic testing results. The original utilization review (09-01-15) non certified the request for left cubital release, left De Quervain's and left epicondyle debridement, and left carpal tunnel release.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Cubital tunnel release surgery: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Elbow Complaints 2007.

**MAXIMUS guideline:** Decision based on MTUS Elbow Complaints 2007, Section(s): Ulnar Nerve Entrapment.

**Decision rationale:** This is a request for left cubital tunnel surgery or decompression of the left ulnar nerve at the elbow. Records indicate the injured worker has pain in the neck, low back and extremities attributed to occupational activities in 2009. The widespread symptoms are not consistent with a diagnosis of cubital tunnel syndrome. May 26, 2015 electrodiagnostic testing was minimally abnormal with the ulnar motor conduction from above to below the elbow mildly delayed at 42 m/s (normal greater than 45 m/s), but no slowing of distal ulnar motor or sensory conduction and no denervation of ulnar innervated musculature with electromyography. There is no documentation of specific treatment for cubital tunnel syndrome; the patient is being treated with high-dose narcotics for widespread symptoms including at present methadone and Percocet. The California MTUS notes 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 that are not present in this case. It is further noted that 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 ulnar nerve irritation at night by preventing prolonged elbow flexion while sleeping. Before proceeding with surgery, patients must be apprised of all possible complications including wound infections, anesthetic complications, nerve damage, and the high probability that surgery will not relieve symptoms. Absent findings of severe neuropathy such as muscle wasting which are not present in this case, at least 3-6 months of conservative care should precede a decision to operate (page 37). In this case, the request does not meet guidelines and is determined to be unnecessary.

**Left Dequervains and left Epicondyle debridement:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Elbow Complaints 2007, Section(s): Lateral Epicondylalgia, and Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** This is a request for 2 surgeries for 2 different problems; release of the left first dorsal wrist compartment which is performed for constrictive tendinopathy and left elbow epicondylar debridement (not specified medial or lateral) which is performed for tendinosis. Records indicate the individual has neck, low back and extremity symptoms attributed to 2009 occupational activities. The widespread symptoms are not consistent with a specific anatomic source; only a small minority of symptoms could be attributed to first dorsal wrist compartment tendinopathy or elbow epicondylar debridement. The California MTUS notes that the majority of patients with DeQuervain's syndrome will have resolution of symptoms with conservative treatment. There is no documentation of conservative treatment provided. The vast majority of patients with epicondylar debridement also respond to conservative treatment; again, there is no documentation

of treatment performed for epicondylitis and the majority of records refer to unrelated symptoms and treatment such as with high-dose narcotics presently including methadone and Percocet. The California MTUS notes that there are no quality studies demonstrating efficacy of surgery over non-surgical treatment for epicondylitis and surgery should only be considered, "for patients who fail to improve after a minimum of 6 months of care that includes at least 3-4 different types of conservative treatment (page 36)." In this case, only a minority of symptoms could be attributed to epicondylitis, there is no documentation of nonsurgical epicondylitis treatment and there is no reasonable expectation of substantial functional improvement with the proposed surgery. Therefore, the request is not medically necessary.

**Left Carpal Tunnel release surgery: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** This is a request for left carpal tunnel release. Records indicate the injured worker has neck, low back and extremity symptoms attributed to 2009 occupational activities and being treated with high-dose narcotics including at present methadone and Percocet. The widespread symptoms are not consistent with a diagnosis of left carpal tunnel syndrome. May 26, 2015 electrodiagnostic testing is not consistent with a diagnosis of left carpal tunnel syndrome with the left distal median sensory and motor onset latencies being well within normal limits at 3.0 and 3.4 ms respectively and no evidence of denervation of median innervated musculature with electromyography. With neither the history or electrodiagnostic testing being consistent with left carpal tunnel syndrome as a primary source of symptoms and no documentation of a positive response to non-surgical treatment for left carpal tunnel syndrome including night splinting and carpal tunnel corticosteroid injection, there is no reasonable expectation the proposed surgery would result in functional improvement and the surgery is not medically necessary.