

Case Number:	CM15-0206837		
Date Assigned:	10/23/2015	Date of Injury:	05/09/1989
Decision Date:	12/08/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	10/20/2015

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: Illinois, California, Texas
 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:

This injured worker is a 63-year-old female who sustained an industrial injury on 5/9/89. The mechanism of injury was not documented. The 7/22/13 bilateral upper extremity EMG/nerve conduction study impression documented electrodiagnostic evidence consistent with bilateral carpal tunnel syndrome, and left ulnar neuropathy at the elbow, right was borderline neuropathy at the elbow. The EMG did not show on-going signs of radiculopathy. The 8/27/15 orthopedic report cited grade 5/10 bilateral wrist pain, right greater than left. Pain radiated to the right shoulder blade. Additional symptoms included limited motion, loss of feeling, numbness, popping, snapping, clicking, sleep disturbance and tingling. Symptoms were worse at night. She was last seen on 12/23/13. Right hand exam documented positive Phalen's and compression tests. Tinel's was negative at the carpal tunnel. Wrist and hand range of motion was full with no evidence of atrophy. Prior treatment had included splinting and injections with some benefit, but were no longer effective. Physical therapy had not been tried. Bilateral wrist injections on 12/23/13 did not help at all. Ultrasound of the wrist showed fluid in the carpal tunnel. She reported carpal and cubital tunnel syndrome but nerve conduction studies were not available. A discussion of operative and non-operative treatment options was documented. The injured worker opted for surgery. Authorization was requested for outpatient right carpal tunnel and cubital tunnel release. The 9/14/15 utilization review non-certified the request for outpatient right carpal tunnel and cubital tunnel release as there was no documentation that conservative measures had been exhausted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient right carpal tunnel release and cubital tunnel release: Upheld

Claims Administrator guideline: Decision based on MTUS Elbow Complaints 2007, and Forearm, Wrist, and Hand Complaints 2004, Section(s): Physical Examination.

MAXIMUS guideline: Decision based on MTUS Elbow Complaints 2007, Section(s): Ulnar Nerve Entrapment, and Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations.

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. Criteria include failure to respond to conservative management, including worksite modification. 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. Guideline criteria have not been met. This injured worker presents with bilateral wrist pain with additional symptoms including numbness and tingling, limited motion, popping/snapping/clicking, limited motion, and sleep disturbance. Clinical exam findings were consistent with electrodiagnostic evidence of carpal tunnel syndrome. There was reported borderline ulnar neuropathy at the elbow but no exam findings were documented that correlate with cubital tunnel syndrome. Detailed evidence of up to 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.