

<b>Case Number:</b>	CM15-0023934		
<b>Date Assigned:</b>	02/13/2015	<b>Date of Injury:</b>	05/21/2010
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	01/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/09/2015

### 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: Maryland, Virginia, North Carolina  
 Certification(s)/Specialty: Plastic 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 was a 51 year old female, who sustained an industrial injury, May 21, 2010. The injury was sustained from repetitive motion while working on an assembly line. According to progress note of December 17, 2014 the injured workers chief complaint was severe pain in the right elbow and wrist from repetitive motions with the neck, pushing, pulling, lifting, forward reaching and working at or above the shoulder level. The injured worker characterized the pain as dull with radiating pain to the upper extremities. The pain in the right elbow was rated as 6 out of 10; 0 being no pain and 10 being the worse pain and 7 in the bilateral shoulders. The physical exam noted palpable paravertebral muscle tenderness with spasms. The range of motion was limited with pain. The shoulder region noted tenderness around the anterior glenohumeral region and subacromial space and pain with terminal motion. The right upper extremity noted tenderness at the right elbow medial epicondyle olecranon fossa. There was positive compression test with subsequent Phalen's maneuver and Tinel's sign was positive over the carpal tunnel and positive Tinel's over the cubital tunnel. There was tenderness of the right elbow. There was full range of motion but painful. There was also diminished sensation in the ulnar and radial digits with some thenar atrophy. The patient had undergone previous steroid injection of the cubital tunnel with temporary relief. The electrodiagnostic studies of the cervical neck, on January 4, 2011, were normal with no indications of carpal tunnel syndrome or ulnar neuropathy in the bilateral upper extremities. The electrodiagnostic studies of bilateral upper extremities on July 16, 2013, impression indicates no electrodiagnostic indicators of carpal tunnel syndrome or ulnar neuropathy of the bilateral upper extremities. The test was repeated on

September 8, 2014 and the results remained the same, no electrodiagnostic evidence of entrapment on the right median, right ulnar and right radial nerves or evidence to support radiculopathy in the right upper extremity. The injured worker was diagnosed with status post cervical reconstruction with disc replacement at C4-C5 and anterior discectomy with fusion of C5-C7, right shoulder biceps tendinitis, right carpal tunnel syndrome and medial and lateral epicondylitis of the right elbow. The injured worker previously received the following treatments an MRI of the right elbow, MRI of the left elbow, electrodiagnostic studies of the cervical neck were normal with no indications of carpal tunnel syndrome or ulnar neuropathy in the bilateral upper extremities, injections. On January 6, 2014, the primary treating physician requested authorization for right carpal tunnel release and Right Cubital Tunnel Release and postoperative physical therapy for right wrist 3 times a week for 4 weeks. On January 14, 2015, the Utilization Review denied authorization for Right Cubital Tunnel Release and postoperative physical therapy for right wrist. The denial was based on the MTUS/ACOEM and ODG guidelines. The patient is noted to have previously undergone a steroid injection to the right elbow, cubital tunnel with temporary relief. Qualified medical re-evaluation dated 6/26/14 notes signs and symptoms of right carpal tunnel syndrome and decreased sensation to light touch of all fingers. Electrodiagnostic studies from 9/8/14 note no evidence of right carpal tunnel syndrome or right cubital tunnel syndrome. Previous conservative management of the right wrist and elbow consisted of steroid injection, bracing, medical management, physical therapy and activity modification. Specific bracing for the elbow and prevention from nighttime flexion was not documented.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Right carpal tunnel release:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Indications for Performing Carpal Tunnel Surgery: Clinical Quality Measures. Maggard, Melinda A.; Harness, Neil G.; Chang, Walter T.; Parikh, Janak A.; Asch, Steven M.; Nuckols, Teryl K.; Plastic & Reconstructive Surgery. 126(1):169-179, July 2010.

**Decision rationale:** The patient is a 51 year old female with clear clinical findings of significant right carpal tunnel syndrome that has failed to respond to conservative management of splinting, medical management, activity modification and steroid injection. The patient continues to have positive exam findings of positive carpal compression, Tinel's and Phalen's test and decreased sensation in the median nerve, confirmed by QME. In addition, the patient is noted to have thenar atrophy, which can be a sign of a severe condition. The patient has had previous electrodiagnostic studies that did not show evidence of median nerve compromise. Generally, positive electrical studies are required prior to certification for surgery outlined below: CTS must be proved by positive findings on clinical examination and the diagnosis should be supported by nerve-conduction tests before surgery is undertaken. Mild CTS with normal electrodiagnostic studies (EDS) exists, but moderate or severe CTS with normal EDS is very rare. However, as

stated, there are rare conditions when moderate or severe CTS has normal EDS. This may be one of those cases. The patient has clinically diagnosed right carpal tunnel syndrome that has failed extensive conservative management. From the above reference: 'For patients with mild or moderate symptoms, a lack of electrodiagnostic confirmation makes surgery inappropriate unless the presentation reflects a high probability of carpal tunnel syndrome and an attempt at conservative therapy has failed (thereby allowing patients with false-negative tests to undergo surgery).' Thus, this is one of those rare cases and right carpal tunnel release should be considered medically necessary. To address the concerns of the UR, the documentation is consistent with a previous steroid injection to the right carpal tunnel.

**Right cubital tunnel release:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 37. Decision based on Non-MTUS Citation Effective Surgical Treatment of Cubital Tunnel Syndrome Based on Provocative Clinical Testing without Electrodiagnostics. Greenwald, Daniel; Blum, Louis C. III; Adams, Dawn; Mercantonio, Cynthia; Moffit, Moriah; Cooper, Benjamin. *Plastic & Reconstructive Surgery*. 117(5):87e-91e, April 15, 2006.

**Decision rationale:** The patient is a 51 year old female with signs and symptoms of possible ulnar nerve compromise at the elbow. She has a positive Tinel's at the elbow and decreased sensation in the ulnar nerve. She has undergone physical therapy, steroid injection and stated bracing. However, there had been no apparent specific documentation of elbow pads, removing the opportunity to rest the elbow on the ulnar groove, and prevention of nighttime elbow flexion. In addition, the electrodiagnostic studies did not support that there was ulnar nerve entrapment at the elbow. As with carpal tunnel syndrome, there can be a false negative rate as described in the reference provided. However, the adherence to conservative management has not been as well documented for this condition as for the carpal tunnel syndrome. Therefore, cubital tunnel release should not be considered medically necessary. From ACOEM, Chapter 10, page 37: 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. From the reference, Overreliance on electrophysiologic testing as an indicator for surgical decompression is not recommended. Electromyography and nerve conduction velocity studies may have false-negative rates in excess of 10 percent in individuals presumed to have cubital tunnel syndrome based on clinical evidence. False-negative electrodiagnostic tests may arise because very few axons need to be functional for the study to be interpreted as normal. Some authors have suggested that noncompressed nerve fibers sampled by the electrodiagnostic test lead to false-negative results in patients with clinical signs of the disease.

**Post-op physical therapy for right wrist:** 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): 15 and 16.

**Decision rationale:** As the decision for right carpal tunnel syndrome was considered medically necessary, post operative physical therapy should be considered medically necessary based on the following guidelines: Recommended as indicated below. There is limited evidence demonstrating the effectiveness of PT (physical therapy) or OT (occupational therapy) for CTS (carpal tunnel syndrome). The evidence may justify 3 to 5 visits over 4 weeks after surgery, up to the maximums shown below. Carpal tunnel syndrome (ICD9 354.0): Postsurgical treatment (endoscopic): 3-8 visits over 3-5 weeks\* Postsurgical physical medicine treatment period: 3 months Postsurgical treatment (open): 3-8 visits over 3-5 weeks\* Postsurgical physical medicine treatment period: 3 months However, the request was for a total of 12 therapy visits which should be considered outside the above guidelines and not medically necessary.