

Case Number:	CM15-0036638		
Date Assigned:	03/05/2015	Date of Injury:	08/01/2013
Decision Date:	04/09/2015	UR Denial Date:	02/13/2015
Priority:	Standard	Application Received:	02/26/2015

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:

The injured worker is a 61-year-old female who sustained an industrial injury on 8/1/13. Injury occurred when a heavy lid fell and struck the dorsum of her right wrist. Past medical history was positive for diabetes. X-rays showed an old ulnar styloid tip nonunion. The 9/23/13 right wrist MRI revealed the ulnar styloid non-union, extensor carpi ulnaris (ECU) tenosynovitis, and some intrasubstance degeneration of the triangular fibrocartilage complex (TFCC). The 12/18/13 EMG/NCV documented electrodiagnostic evidence of moderate right carpal tunnel syndrome and right ulnar neuropathy at the elbow. The 10/18/14 orthopedic report cited dorsal and ulnar wrist pain with numbness and tingling in all digits. Conservative treatment included 3 months use of elbow and wrist splints, corticosteroid injections to the carpal tunnel and TFCC, and activity modification. Physical exam documented positive ulnar nerve subluxation and positive hyperflexion test over the right elbow, with negative Tinel's. Right carpal tunnel exam documented positive Tinel's and Phalen's tests. There was positive right ulnar fovea sign, stable distal radial ulnar joint, and mild ECU tenderness. The diagnosis was right carpal tunnel syndrome, cubital tunnel syndrome, TFCC tear, and ECU tenosynovitis. Surgery was recommended. The 11/19/14 treating physician report cited continued pain and numbness over the ulnar aspect of the right forearm and hand, tenderness over the right cubital tunnel, and ulnar tenderness over the wrist. The ECU injection was not helpful. Exam documented positive TFCC grind test, positive Tinel's over the cubital tunnel, and hypesthesia in an ulnar distribution. Surgical authorization was requested. The 1/9/15 medical legal report documented the injured worker had failed to respond to a prolonged course of rest, splinting, corticosteroid injections,

medications, and therapy. The diagnosis included right ECU tenosynovitis with possible TFCC tear, cubital tunnel syndrome, and status post right wrist contusion. The 1/29/15 right wrist MR arthrogram revealed a central TFCC tear and tenosynovitis. The 2/5/15 orthopedic report indicated the patient had attempted conservative treatment for her carpal and cubital tunnel syndrome, TFCC tear, and ECU tenosynovitis without sustained benefit. Surgery was requested to include right wrist arthroscopy, excision versus repair of triangular fibrocartilage complex tear, endoscopic cubital tunnel release, possible open medial epicondylectomy, endoscopic carpal tunnel release, and possible sixth dorsal compartment release. On 2/13/15, Utilization Review modified the request for right wrist arthroscopy, excision versus repair of triangular fibrocartilage complex tear, endoscopic cubital tunnel release, possible open medial epicondylectomy, endoscopic carpal tunnel release, and possible sixth dorsal compartment release to right wrist arthroscopy and repair of triangular fibrocartilage complex tear. The rationale noted a lack of detailed documentation relative to carpal and cubital tunnel splinting and exercise. The request for 12 sessions of post-op occupational therapy were modified to 5 sessions of status post occupational therapy. The ACOEM Guidelines were cited. On 2/26/15, the injured worker submitted an application for IMR.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Wrist arthroscopy , debridement, excision versus repair of triangular fibrocartilage complex tear endoscopic cubital tunnel release, possible open possible medial epicondylectomy endoscopic carpal tunnel release possible sixth dorsal compartment release right: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 34-35, 37-38, 270. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): Elbow chapter 36-38; Forearm, Wrist & Hand Chapter 270. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM). Occupational Medical Practice Guidelines 2nd Edition. Chapter 11 Hand, Wrist and Forearm Disorders (Update 2009), page(s) 80-81.

Decision rationale: The California MTUS guidelines state that surgical consideration may be indicated for patients who fail to respond to conservative management, and have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention. The ACOEM guidelines state that surgical repair of subacute or chronic triangular fibrocartilage complex tears is recommended for patients with instability, concomitant fractures or symptoms that persist without trending towards resolution despite non-operative treatment for 3 to 6 weeks. 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. 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. 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 been met. This injured worker presents with persistent function-limiting right elbow and hand pain and paresthesias. There is imaging evidence of a TFCC tear and ECU tenosynovitis. There is electrodiagnostic evidence of moderate right carpal tunnel syndrome and right ulnar neuropathy. Clinical exam findings are consistent with imaging and electrodiagnostic studies. Detailed evidence of at least 6 months of a recent, reasonable and/or comprehensive guideline-recommended non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

12 Sessions of status post op occupational therapy: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 22.

Decision rationale: The California Post-Surgical Treatment Guidelines for cubital tunnel release suggest a general course of 20 post-operative visits over 10 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 10 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. This is the initial request for post-operative physical therapy and, although it exceeds recommendations for initial care, is within the recommended general course. Therefore, this request is medically necessary.