

Case Number:	CM15-0053337		
Date Assigned:	03/26/2015	Date of Injury:	06/08/2004
Decision Date:	05/05/2015	UR Denial Date:	02/24/2015
Priority:	Standard	Application Received:	03/20/2015

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: Minnesota, Florida
 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 orthopedic surgery and spine surgery initial consultation dated February 12, 2015 indicates that the injured worker is a 52-year-old right-hand-dominant male who presents with severe neck pain, bilateral shoulder pain and upper extremity weakness. The neck pain and low back pain started in April 2004. He underwent an anterior cervical discectomy and fusion using allograft at C5-6 and C6-7. In 2007, he underwent a lumbar decompression and fusion with instrumentation from L3 to sacrum. He was then managed by a Pain Management Physician who put him on Opana and Norco. Over the past several years there was increasing neck pain with numbness of the right arm. EMG and nerve conduction studies revealed a right cubital tunnel and right carpal tunnel syndrome. The neck pain was radiating into the deltoid and biceps region bilaterally. He had numbness of the left lateral arm and right index finger. Examination of the cervical spine revealed a positive Spurling on the right and negative on the left. Deep tendon reflexes in the lower extremities were diminished. There was no clonus. He could walk on tiptoes and on heels. Examination of the upper extremities revealed absence of deep tendon reflexes. Grip strength was 50 pounds on the right and 120 pounds on the left. There was decreased sensation in the left C5 and right median nerve distribution. The circumferences of the right forearm and upper arm were slightly less than the left. There was no atrophy in the small muscles of the hand documented. MRI scan of the cervical spine dated July 23, 2014 revealed bilateral C5 radiculitis secondary to C4-5 degenerative spondylolisthesis with foraminal stenosis. The fusion hardware was noted. Fusion was said to be solid. A hand surgery consultation of February 11, 2015 indicated that the right arm symptoms were present since 1990s. Examination of the right hand

revealed 5/5 strength in the extensor pollicis longus, abductor pollicis brevis, and first dorsal interosseous muscle. There was a positive Phalen's on the right, positive elbow flexion test and Tinel's was positive over the cubital tunnel and carpal tunnel. Semmes Weinstein monofilament testing showed a threshold of 2.83 in all digits of the right hand. The examining provider suggested surgery for the carpal tunnel and cubital tunnel. No conservative treatment was prescribed. Nerve conduction study dated 11/13/2014 is noted. The distal motor latency of the right median nerve was 4.25ms. The needle electromyography was entirely negative for denervation. There was slowing of the right motor ulnar nerve conduction across the elbow. The sensory responses were normal for the ulnar nerve. The impression was mild right carpal tunnel syndrome and mild cubital tunnel syndrome. A request for a right carpal tunnel release and cubital tunnel release vs. anterior transposition of the ulnar nerve was noncertified by utilization review. The rationale was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right endoscopic release vs open carpal tunnel release and right cubital tunnel release vs ulnar nerve transposition: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 265, 270, 272, 37.

Decision rationale: With regard to carpal tunnel syndrome the guidelines indicate that patients with mild carpal tunnel syndrome generally don't do as well with surgery as those with moderate or severe carpal tunnel syndrome. The guidelines indicate that initial treatment of carpal tunnel syndrome should include night splints. The splints can also be considered for patient's comfort during the day as needed to reduce pain along with work modifications. The guidelines recommend an injection of corticosteroids about the tendon sheaths or possibly the carpal tunnel in patients who are resistant to conservative therapy for 8-12 weeks. The initial treatment is with a splint and medication before injection is considered except in the case of severe carpal tunnel syndrome with thenar muscle atrophy and constant paresthesias in the median innervated digits. Symptomatic relief from a corticosteroid injection will facilitate the diagnosis; however, the benefit from these injections is short-lived. The available documentation does not indicate injections of corticosteroids have been given or a trial of splinting and medication has been carried out. The electrophysiologic studies revealed mild carpal tunnel syndrome. As such, the request for a carpal tunnel release is not supported by guidelines and the medical necessity of the request has not been substantiated. California MTUS guidelines with regard to the cubital tunnel syndrome indicate surgical considerations after establishing a firm diagnosis on the basis of clear clinical evidence and positive electrical studies that correlate with the clinical findings. A decision to operate requires significant loss of function as reflected in significant activity limitations due to the nerve entrapment and that patient has failed conservative care, including full compliance in therapy, use of elbow pads, removing opportunities to rest the elbow on the ulnar groove, 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. The electrophysiologic studies show evidence of mild cubital tunnel syndrome. There is no denervation potential in the first dorsal interosseous muscle and there is no muscle wasting noted. The documentation submitted does not indicate 3-6 months of the above conservative care. In consideration of the foregoing issues and the referenced evidence-based guidelines, the medical necessity of the requested surgery has not been established and is not medically necessary.