

Case Number:	CM15-0087311		
Date Assigned:	05/11/2015	Date of Injury:	10/22/2010
Decision Date:	06/26/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	05/06/2015

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 is a 51 year old male, who sustained an industrial injury on 10/22/2010. He reported injuries to his bilateral upper extremities due to repetitive typing and similar activities. The injured worker is currently on modified duty. The injured worker is currently diagnosed as having repetitive overuse syndrome to both upper extremities. Treatment and diagnostics to date has included electromyography, physical therapy, acupuncture, right carpal tunnel release, local trigger injections, and medications. In a progress note dated 12/02/2014, the injured worker presented with complaints of right thumb and right elbow irritability. Objective findings include diffuse irritability to the right elbow and right thumb. The treating physician reported requesting authorization for left carpal tunnel release, physical therapy, and MRI of the right elbow and forearm and right wrist. Documentation of conservative management to date included carpal tunnel injections to both wrists with incomplete relief, splinting including at night, physical therapy, acupuncture, modified activity and NSAIDs. Electrodiagnostic studies from 11/5/14 noted mild left carpal tunnel syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left carpal tunnel release: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 263-270; 602. Decision based on Non-MTUS Citation Official Disability Guidelines, Carpal Tunnel Chapter, Indications for surgery.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270 and 272.

Decision rationale: The patient is a 51 year old male with signs and symptoms of left carpal tunnel syndrome, including positive Tinel's and moderate thenar atrophy. This has been present for several years and he has undergone well-documented conservative management including NSAIDs, activity modification, PT, acupuncture, splinting and carpal tunnel injection. Electrodiagnostic studies documented a mild left carpal tunnel syndrome. From page 270, ACOEM, Chapter 11, "Surgical decompression of the median nerve usually relieves CTS symptoms. High-quality scientific evidence shows success in the majority of patients with an electrodiagnostically confirmed diagnosis of CTS. Patients with the mildest symptoms display the poorest post surgery results; patients with moderate or severe CTS have better outcomes from surgery than splinting. 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." Further from page 272, Table 11-7, injection of corticosteroids into to the carpal tunnel is recommended in mild to moderate cases of carpal tunnel syndrome after trial of splinting and medication. Based on ACOEM guidelines, left carpal tunnel release should be considered medically necessary. The patient has satisfied conservative management, including splinting to help satisfy the reasons for denial by the UR. Although the patient does not have all the signs of carpal tunnel syndrome, based on the entirety of the medical record including completed conservative management and positive EDS, the patient should be considered a surgical candidate for carpal tunnel release. Left carpal tunnel release should be considered medically necessary.

MRI of right elbow and forearm: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 602. Decision based on Non-MTUS Citation Official Disability Guidelines, Elbow.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

Decision rationale: The patient is a 51 year old male with a history of right elbow complaints including possible right ulnar nerve irritation at the elbow and right elbow lateral epicondylitis. Ulnar nerve transposition was not authorized. Therefore, the patient was considered for physical therapy of the right elbow. An MRI of the right elbow was requested. A right elbow steroid injection was offered but denied by the patient. From page 42, elbow chapter, an MRI is specifically not recommended for epidcondylagia. An MRI is recommended for suspected ulnar collateral ligament tears. Plain film radiography is recommended for red-flag cases. Overall,

there is insufficient documentation that an MRI evaluation is necessary for the right elbow. The patient has signs and symptoms of possible right lateral epicondylitis and cubital tunnel syndrome. The patient is to undergo physical therapy of the right elbow and thus, an MRI should not be considered medically necessary. With further conservative therapy and other signs of possible pathology, an MRI could be re-considered.

MRI of right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270.

Decision rationale: The patient is a 51 year old male with a history of right carpal tunnel release who had requested MRI of the right wrist. There has been insufficient documentation to warrant an MRI evaluation of the wrist. Reports from any radiographic studies have not been presented. Adequate conservative management of any continue right wrist pain or other reasoning on examination to warrant an MRI evaluation has not been presented. Therefore, an MRI of the right wrist should not be considered medically necessary. From page 270, ACOEM, Referral for hand surgery consultation may be indicated for patients who: Have red flags of a serious nature, Fail to respond to conservative management, including worksite modifications, 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. Surgical considerations depend on the confirmed diagnosis of the presenting hand or wrist complaint. If surgery is a consideration, counseling regarding likely outcomes, risks and benefits, and, especially, expectations is very important. If there is no clear indication for surgery, referring the patient to a physical medicine practitioner may aid in formulating a treatment plan.

12 sessions of Physical Therapy to bilateral wrists and right elbow: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Post surgery physical therapy.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 11, 15 and 16.

Decision rationale: The patient is a 51 year old male who was certified for left carpal tunnel syndrome. In addition, the patient has left elbow complaints with non-certification of a left ulnar transposition surgery. He is noted to complain of possible left lateral epicondylitis as well. As the carpal tunnel release was considered medically necessary, postoperative physical therapy should be considered medically necessary based on the following guidelines: From page 15 and 16, 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.

Benefits need to be documented after the first week, and prolonged therapy visits are not supported. Carpal tunnel syndrome should not result in extended time off work while undergoing multiple therapy visits, when other options (including surgery for carefully selected patients) could result in faster return to work. Furthermore, carpal tunnel release surgery is a relatively simple operation that also should not require extended multiple therapy office visits for recovery. 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 week. Postsurgical physical medicine treatment period: 3 months "Initial course of therapy" means one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d)(1) of this section. Therefore, based on these guidelines, 12 visits would exceed the initial course of therapy guidelines and should not be considered medically necessary. Up to 4 visits would be consistent with these guidelines. However, as the patient should exhaust conservative therapy for his right elbow complaints, an additional 8 physical therapy visits should be considered medically necessary.