

Case Number:	CM14-0138131		
Date Assigned:	09/05/2014	Date of Injury:	03/13/2014
Decision Date:	10/17/2014	UR Denial Date:	07/24/2014
Priority:	Standard	Application Received:	08/26/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Orthopedic Sports Medicine and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 60 year old male plumber whose date of injury is 03/13/14 when he was digging and began to experience diminished sensation along the ulnar nerve distribution, possibly the median nerve distribution. The injured worker received 6 physical therapy sessions, and was given oral medication. EMG/NCV done 06/02/14 showed evidence of left carpal tunnel, and left ulnar neuropathy more likely at the elbow but the injured worker also has delayed sensory conduction velocity at the wrist. syndrome. X-rays of the left elbow were normal. Physical examination of the left elbow on 07/16/14 revealed several degrees of recurvatum, positive Tinel's over the ulnar nerve at the left elbow, and tenderness to palpation of the medial epicondyle. At the left wrist there is positive Tinel's over the median nerve; Phalen's test is positive. Motor strength was 4+/5. There is no muscle atrophy. Reflexes are symmetric. The injured worker was recommended to undergo left ulnar nerve decompression with possible transposition, and left carpal tunnel release.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgery - Left Ulnar Nerve Decompression possible transposition Left Carpal Tunner Release @ Fresno Surgical Hospital.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabiligy Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation ODG) Elbow, Surgery for cubital tunnel syndrome (ulnar nerve entrapment); Carpal tunnel syndrome, Carpal tunnel release surgery (CTR)

Decision rationale: Per ACOEM, 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 postsurgery 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. For patients with not severe carpal tunnel syndrome, there should be documentation of at least 2 of the following: abnormal Katz diagram scores; nocturnal symptoms; flick sign. Physical exam should show at least 2 of the following: positive compression test; Semmes-Weinstein monofilament test; Phalen's sign; Tinel's sign; decreased 2-point discrimination; mild thenar weakness. There should be failure to respond to conservative care with at least 3 of the following: activity modification, night splinting, anti-inflammatory medication, home exercise program, and corticosteroid injection prior to consideration of surgical intervention. The injured worker does have positive subjective complaints and objective findings consistent with carpal tunnel syndrome confirmed by electrodiagnostic testing; however, there is no documentation that the injured worker has had night splinting and/or injection of the carpal tunnel. As such, medical necessity is not established for left carpal tunnel release. As to the request for left ulnar nerve decompression with possible nerve transposition, ODG recommends surgery for patients with ulnar neuropathy who have failed initial conservative treatment including all of the following: exercise, activity modification, medications, and elbow pad/splint. Simple decompression is recommended, and transposition may only be required if the ulnar nerve subluxes on ROM of the elbow. There is no documentation that the injured worker has had a trial of elbow padding/splinting. Also, there is no evidence of ulnar nerve subluxation that would support the need for transposition. As such, medical necessity is not established for left ulnar nerve decompression with possible transposition.

Preoperative Labs: CBC, Basic Metabolic: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Per ACOEM, 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 postsurgery 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.

Decision rationale: Preoperative lab testing may be indicated in some instances for patients who are to undergo surgery if there are co-morbid conditions; however, since medical necessity has not been established for surgical intervention in this case, there is no need for pre-op testing.

Postoperative Physical therapy quantity 12: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: CA MTUS supports 3-8 visits over 3-5 weeks following carpal tunnel release. The guidelines also support up to 20 visits over 3 months following cubital tunnel release. However, since medical necessity has not been established for surgical intervention, there is no need for post-op physical therapy.