

Case Number:	CM14-0155477		
Date Assigned:	10/06/2014	Date of Injury:	03/03/2014
Decision Date:	10/30/2014	UR Denial Date:	09/18/2014
Priority:	Standard	Application Received:	09/23/2014

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, and is licensed to practice in California. 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:

This 38-year-old female medical assistant sustained an industrial injury on 3/3/14. Onset of right hand/wrist pain was reported relative to doing a large volume of writing and preparing patient charts. The initial working diagnosis was carpal tunnel syndrome. The 4/8/14 electrodiagnostic study impression documented an abnormal nerve conduction study with mild compression of the right ulnar nerve at or near the medial epicondyle. There was no other evidence of entrapment neuropathy or active cervical radiculopathy in the right upper extremity. The progress reports from 3/18/14 to 8/14/14 do not consistently document positive carpal tunnel provocative testing. Conservative treatment included wrist bracing, night-time elbow bracing, physical therapy, and activity modification with no sustained improvement. The 9/11/14 orthopedic report cited severe medial and lateral elbow pain at rest, worsened with writing/keying. There was right hand numbness, tingling, and lack of coordination and endurance. Physical exam documented 3+ tenderness over the lateral epicondyle with positive resisted extension pain. There was 3+ tenderness over the ulnar nerve at the cubital tunnel and positive elbow flexion test. There was decreased right hand intrinsic bulk with 5-/5 strength and decreased grip strength. Tinel's and Phalen's signs were positive at the right carpal tunnel. Two-point discrimination was 7-8 mm at the fingers. The patient had failed 6 months of anti-inflammatory medication, splints, work restriction, and rest with no improvement. Surgery was requested to include right carpal tunnel release, cubital tunnel release and lateral epicondylar release. The 9/18/14 utilization review modified the request for right carpal tunnel release, cubital tunnel release, and lateral epicondylar release and denied the request for lateral epicondylar release based on an absence of documented conservative treatment failure specific to the lateral epicondylar condition.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right carpal tunnel release, right cubital tunnel release: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 36-37, 270.

Decision rationale: The California 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. The California 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, 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. 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 for proceeding with right cubital tunnel release based on clinical exam and electrodiagnostic evidence. Exam findings currently document positive carpal tunnel syndrome provocative testing but that has not been consistent in the progress reports from 3/18/14 to 8/19/14. There is no electrodiagnostic evidence to support the diagnosis of right carpal tunnel syndrome. The 9/18/14 utilization review modified the global surgical request and approved right carpal tunnel and cubital tunnel release. The medical necessity of additional authorization is not established. Therefore, this request is not medically necessary.

Lateral epicondylar release right elbow, right wrist, right elbow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 6043-605.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 35-36.

Decision rationale: The California MTUS updated ACOEM elbow guidelines state that surgery for lateral epicondylalgia should only be a consideration for those patients who fail to improve after a minimum of 6 months of care that includes at least 3-4 different types of conservative treatment. However, there are unusual circumstances in which, after 3 months of failed conservative treatment, surgery may be considered. Although some individuals will improve with surgery for lateral epicondylalgia, at this time there are no published RCTs that indicate that surgery improves the condition over non-surgical options. Guideline criteria have not been met. Evidence of 6 month(s) of a recent, reasonable and/or comprehensive non-operative guideline-recommended treatment protocol trial, directed to the elbow for the diagnosis of lateral

epicondylitis and failure has not been submitted. Guideline-recommended conservative treatment for lateral epicondylitis has been limited to acupuncture provided in June 2014 based on review of the provided records. Therefore, this request is not medically necessary at this time.