MAXIMUS Federal Services

Case Number:	CM14-0161161		
Date Assigned:	10/06/2014	Date of Injury:	01/16/2010
Decision Date:	11/06/2014	UR Denial Date:	09/10/2014
Priority:	Standard	Application Received:	10/01/2014

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 Hand Surgery, 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 65-year-old female who reported injury on 01/16/2010. Reportedly the injured worker's hand was crushed from a lid of a large laundry bin. The injured worker's treatment history included history of superficial radial nerve neurolysis and ganglion cyst excision in 05/2010, status post ORIF non-union right middle metacarpal fracture, PIN neurectomy, synovectomy on 07/19/2013. On 05/12/2014 the injured worker underwent an aspiration of ganglion, and medications. The injured worker had an injection and aspiration of ganglion on 08/11/2014 to the right forearm that was noted to be helpful for a few days only. The injured worker was evaluated on 09/30/2014 and it was documented the injured worker was complaining of pain in the distal forearm and right middle trigger finger. Physical examination of the right hand revealed tender A-1 pulley right middle finger, Tinel's over the dorsum of the right hand with tenderness over the intersection point. Diagnoses included persistent pain in the distal forearm from radial nerve compression, Wartenberg's syndrome, and trigger finger of the right middle finger, stenosing tenosynovitis. Both have not been respondent to conservative measures. Diagnosis included Wartenberg's (Note in file states Wartenberg's) syndrome. The Request for Authorization dated 10/08/2014 was for radial nerve neurolysis right forearm and nerve wrap for right forearm.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right forearm radial nerve neurolysis: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 26 and 44-49.

Decision rationale: The request is not medically necessary. Per MTUS/ACEOM, radial nerve entrapment, particularly of the posterior interosseous branch of the radial nerve, causes proximal forearm aching and pain that persists despite presumably effective treatment. It is clinically somewhat difficult to distinguish from non-specific forearm and elbow pain, and it is sometimes referred to as "resistant tennis elbow" or "supinator syndrome." A relatively rare condition, radial nerve entrapment is estimated to be approximately 30- to 100-fold less common than carpal tunnel syndrome. There are multiple sites for potential entrapment. Most commonly, these sites include the extensor carpi radialis brevis origin, fibrous bands overlying the radial head, radial recurrent arterial fan, and the arcade of Frohse at the entrance to the supinator muscle. A confirmatory electrodiagnostic motor study is helpful, but often difficult to obtain. There are no quality studies on which to rely for the treatment of radial neuropathies and there is no evidence of benefits of the following treatment options. However, these options are low cost, have few side effects, and are not invasive. Thus, while there is insufficient evidence to support their use, they are recommended: use of a wrist splint for periodic daytime use rather than continuous use; although not particularly successful for neuropathic pain, utilization of NSAIDs (non-steroidal anti-inflammatory drugs). Referral for surgical consultation may be indicated for patients who have: significant limitations of activity for more than 3 months; failure to improve with exercise programs to increase range of motion and strength of the musculature around the elbow; or clear clinical and electrophysiologic or imaging evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. Emergency consultation is reserved for patients who require drainage or aspiration of acute septic effusions, ruptures (e.g., biceps), infected hematomas, and/or drainage of infected bursitis, or who have severe acute nerve impingement. The documentation that was submitted failed to include a confirmatory electrodiagnostic motor study to confirm the injured worker's having Wartenberg's syndrome. Furthermore, the documentation submitted indicated the injured worker has failed conservative care measures; however the duration of failed conservative measures were not submitted for this review. As such, the request for right forearm radial nerve neurolysis is not medically necessary.

Right forearm nerve wrap: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 26.

Decision rationale: The request is not medically necessary. Per MTUS/ACEOM, radial nerve entrapment, particularly of the posterior interosseous branch of the radial nerve, causes proximal forearm aching and pain that persists despite presumably effective treatment. It is clinically somewhat difficult to distinguish from non-specific forearm and elbow pain, and it is sometimes

referred to as "resistant tennis elbow" or "supinator syndrome." A relatively rare condition, radial nerve entrapment is estimated to be approximately 30- to 100-fold less common than carpal tunnel syndrome. There are multiple sites for potential entrapment. Most commonly, these sites include the extensor carpi radialis brevis origin, fibrous bands overlying the radial head, radial recurrent arterial fan, and the arcade of Frohse at the entrance to the supinator muscle. A confirmatory electrodiagnostic motor study is helpful, but often difficult to obtain. There are no quality studies on which to rely for the treatment of radial neuropathies and there is no evidence of benefits of the following treatment options. However, these options are low cost, have few side effects, and are not invasive. Thus, while there is insufficient evidence to support their use, they are recommended: use of a wrist splint for periodic daytime use rather than continuous use; although not particularly successful for neuropathic pain, utilization of NSAIDs (non-steroidal anti-inflammatory drugs). The document submitted failed to include a confirmatory electrodiagnostic motor study. Moreover, the provider failed to include documentation of failed conservative care measures. As such, the request for right forearm nerve wrap is not medically necessary.