MAXIMUS Federal Services

Case Number:	CM14-0162067		
Date Assigned:	10/07/2014	Date of Injury:	04/22/2013
Decision Date:	11/03/2014	UR Denial Date:	09/15/2014
Priority:	Standard	Application Received:	10/02/2014

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 58-year-old male machine operator sustained an industrial injury on 4/22/13.Past surgical history was positive for left carpal tunnel release on 6/10/13 with residual complaints of pain, left hand weakness, and limited motion of the left thumb and small finger. The 2/11/14 hand surgery consults reported complaints of numbness and tingling in the right hand and middle, ring and small fingers. The patient was not taking any current medications. Right upper extremity exam documented full active range of motion of the right forearm, wrist, and fingers with normal strength. Sensation was intact to pinprick in all fingers of both hands. Tinel's test was positive on the right at the carpal tunnel and elbow. Ulnar compression test was positive at the elbow. The patient reported no functional difficulty in activities of daily living. The diagnosis was right carpal tunnel syndrome and probable right ulnar entrapment neuropathy at the elbow. Treatment alternatives were discussed including observation, avoidance of leaning on the elbow or maintaining the elbow flexes, wrist splint at night, soft elbow support, elbow night splint, cortisone injection, electrodiagnostic testing, right carpal tunnel release surgery, and ulnar nerve decompression and anterior transposition surgery. The patient wished to proceed with electrodiagnostic testing and surgery. The 3/25/14 right upper extremity EMG/NCV study impression documented an abnormal study. Findings were consistent with moderate carpal tunnel syndrome and mild cubital tunnel syndrome. There was no electrophysiological evidence of radial nerve entrapment of motor radiculopathy. The 5/27/14 hand surgery report cited complaints of right hand and finger numbness, worse in the ring and small fingers. There was outer right elbow pain and right shoulder pain. Physical exam documented full active bilateral forearm, wrist and finger range of motion. Manual muscle testing of each hand was normal. Sensation was decreased to pinprick over the right thumb, index and long fingers. Sensation was intact and possibly hypersensitive in the right ring and small fingers, and intact over the

hypothenar and dorsal ulnar hand. All neurologic provocative testing was negative bilaterally. The diagnosis was right carpal tunnel syndrome and right ulnar entrapment neuropathy at the elbow, electro diagnostically positive. Authorization was requested for right endoscopic carpal tunnel release, possible open and surgical right ulnar neurolysis at the elbow, and possible anterior submuscular transposition. The 9/15/14 utilization review denied the request for right carpal tunnel release and ulnar nerve surgery as there was no documentation of conservative treatment failure or recent EMG findings.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right carpal tunnel release, with possible open and right ulnar neurolysis at the elbow, possible anterior submuscular transposition: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation ACOEM Practice Guidelines New Elbow Chapter page 40-43, table 4 surgical consideration

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

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. Criteria include failure to respond to conservative management, including worksite modification. The California MTUS elbow 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 not been met. There are no current findings of severe neuropathy, such as muscle wasting. The 3/25/14 electrodiagnostic testing findings were consistent with moderate right carpal tunnel syndrome and mild cubital tunnel syndrome. Current physical exam documented negative carpal and cubital tunnel syndrome provocative testing. There was no documentation of functional difficulty. Evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial for the right upper extremity and failure has not been submitted. Therefore, this request is not medically necessary.