Case Number:	CM15-0110543		
Date Assigned:	06/17/2015	**Date of Injury:**	11/21/2012
Decision Date:	08/25/2015	**UR Denial Date:**	05/27/2015
Priority:	Standard	**Application Received:**	06/08/2015

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: California
Certification(s)/Specialty: Orthopedic Surgery, Hand Surgery, Sports Medicine

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 66 year old male who sustained an industrial injury on November 21, 2012. He has reported injury to the left hand and thumb and has been diagnosed with lesion of ulnar nerve, carpal tunnel syndrome, osteoarthritis, and hand pain. Treatment has included surgery, therapy, injections, acupuncture, splinting, medications, and activity modification. Palpation of the left wrist revealed mild tenderness at the first dorsal compartment. There was mild tenderness over the dorsal SL interval. Ulnar wrist examination reveals mild tenderness at the TFCC, ECU, or FCU. There was tenderness to palpation at the first cmc joint, radiocarpal joint, and DRUJ. Range of motion of the wrist showed extension at 80 degrees, flexion at 80 degrees, pronation at 80 degrees, and supination at 80 degrees. Wrist range of motion was mildly restricted. X-rays revealed moderate severe arthritis throughout many compartments including DRJ, radiocarpal joint, and first cmc joint. The treatment request included medications, a left cubital tunnel release, and 12 visits of post-operative hand therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Carpal tunnel release (left): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 18-19, 36-38.

Decision rationale: This is a request for CUBITAL tunnel release or decompression of the ulnar nerve at the inner elbow. The CA MTUS recommends initial non-invasive treatment with elbow padding, avoidance of pressure on the nerve, avoidance of hyperflexion of the elbow and nonsteroidal anti-inflammatory medications records provided do not document non-surgical treatment for presumed cubital tunnel syndrome. The California MTUS notes, "Surgery for ulnar nerve entrapment requires establishing a firm diagnosis on the basis of clear medical evidence and positive electrical studies that correlate with clinical findings." Records provided document diffuse symptoms such as in the outer elbow and thumb which do not correlate with ulnar neuropathy at the elbow; the records suggest electrodiagnostic testing was performed, but the results of the testing were not forwarded for review. The California MTUS goes on to note, "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 proceed a decision to operate." The records provided do not document clear clinical evidence and correlating electrical studies of ulnar neuropathy or sufficient loss of function despite appropriate non- surgical treatment to support the request for cubital tunnel decompression surgery at this time. Therefore, the request is not medically necessary.

Postoperative hand therapy (12 visits): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

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

Decision rationale: The California MTUS supports 20 therapy sessions over 3 months following cubital tunnel release surgery. An initial course of therapy is defined as one half the maximal number of visits (page 10) 10 sessions after cubital tunnel surgery. Additional therapy sessions up to the maximum allowed is appropriate only if there is documented functional improvement defined as clinically significant improvement in activities of daily living or a reduction in work restrictions and a reduction in the dependency on continued medical treatment (page 1). The requested 12 sessions exceeds guidelines. Therefore, the request is not medically necessary.

Preoperative surgical clearance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Preoperative Testing Before Non-cardiac Surgery: Guidelines and Recommendations Molly A. Feely, MD; C. Scott Collins, MD; Paul R. Daniels, MD; Esayas B. Kebede, MD; Aminah Jatoi, MD; and Karen F. Mauck, MD, MSc, Mayo Clinic, Rochester, Minnesota Am Fam Physician. 2013 Mar 15; 87(6):414-418.

Decision rationale: An extensive systematic review referenced above concluded that there was no evidence to support routine preoperative testing. More recent practice guidelines recommend testing in select patients guided by a perioperative risk assessment based on pertinent clinical history and examination findings, although this recommendation is based primarily on expert opinion or low-level evidence. In this case, there is no documented medical history to support the need for the requested evaluation; rather, records indicate the injured worker has undergone multiple surgical procedures on February 11, 2015 without medical or anesthetic complications. Therefore, the request is not medically necessary.

Preoperative labs and Electrocardiogram (EKG): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Preoperative Testing Before Non-cardiac Surgery: Guidelines and Recommendations Molly A. Feely, MD; C. Scott Collins, MD; Paul R. Daniels, MD; Esayas B. Kebede, MD; Aminah Jatoi, MD; and Karen F. Mauck, MD, MSc, Mayo Clinic, Rochester, Minnesota Am Fam Physician. 2013 Mar 15; 87(6):414-418.

Decision rationale: An extensive systematic review referenced above concluded that there was no evidence to support routine preoperative testing. More recent practice guidelines recommend testing in select patients guided by a perioperative risk assessment based on pertinent clinical history and examination findings, although this recommendation is based primarily on expert opinion or low-level evidence. In this case, there is no documented medical history to support the need for the requested evaluation; rather, records indicate the injured worker has undergone laboratory testing and EKG earlier this calendar year before multiple surgical procedures in February 2015. Therefore, the request is not medically necessary.