

<b>Case Number:</b>	CM15-0172067		
<b>Date Assigned:</b>	09/11/2015	<b>Date of Injury:</b>	08/16/2013
<b>Decision Date:</b>	10/13/2015	<b>UR Denial Date:</b>	08/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/01/2015

### 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, Oregon, Washington  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 is a 47 year old male with a date of injury of August 16, 2013. A review of the medical records indicates that the injured worker is undergoing treatment for cervical spine myoligamentous injury with right upper extremity radicular symptoms; lumbar bilateral neural foraminal stenosis with bilateral lower extremity radiculopathy, right greater than left; lumbar myoligamentous injury with right lower extremity radicular symptoms; and bilateral carpal tunnel syndrome, right greater than left. Medical records dated July 31, 2015 indicate that the injured worker complains of increased pain in the lower back radiating down both lower extremities, right greater than left with pins and needles sensation. Records also indicate complaints of pain and numbness in both hands, and right wrist pain. A progress note dated July 17, 2015 notes similar complaints. Per the treating physician (July 31, 2015), the employee was temporarily partially disabled with lifting restrictions of no greater than 50 pounds and no repetitive bending and squatting. The physical exam dated July 31, 2015 reveals tenderness to palpation of the bilateral lumbar musculature with increased muscle rigidity, numerous trigger points which were palpable and tender with taut bands throughout the lumbar paraspinal muscles, muscle guarding with range of motion testing of the lumbar spine, decreased range of motion of the lumbar spine (flexion of 45 degrees, extension of 15 degrees, left lateral bending of 20 degrees, right lateral bending of 20 degrees), decreased Achilles tendon reflexes, decreased motor testing of the right ankle extension and right great toe extension, decreased sensation in the posterolateral thigh and posterolateral calf of the right lower extremity, positive straight leg raise in the right, and abnormal motor testing of the right wrist flexors and extensors (5- of 5).

The physical findings were unchanged compared to the examination on July 17, 2015. Treatment has included medications (Norco, Ultracet, Anaprox, Prilosec, and Neurontin since at least May of 2015), lumbar epidural steroid injections (last treatment noted to be on July 10, 2014) with short-term benefit, computed tomography myelogram of the lumbar spine (June 24, 2015) that showed abnormal mild diffuse thickening of multiple nerve roots, electrodiagnostic study of the lower extremities (January 26, 2015) that showed L5 radiculopathy of the right, magnetic resonance imaging of the lumbar spine (July 8, 2015) that showed disc herniations with facet arthropathy at L4-5 and L5-S1 and bilateral neural foraminal narrowing at L5-S1, and electrodiagnostic studies of the bilateral upper extremities (October 14, 2014) that showed bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome. The original utilization review (August 19, 2015) non-certified a request for bilateral carpal tunnel release and a right ulnar nerve decompression and transposition, and trial of a lumbar spinal cord stimulator using high frequency servo system.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Bilateral carpal tunnel release and a right ulnar nerve decompression and transposition:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Elbow Complaints 2007, and Forearm, Wrist, and Hand Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) surgery for carpal tunnel syndrome.

**Decision rationale:** Per the CA MTUS/ACOEM guidelines, Chapter 11 Forearm, Wrist and Hand Complaints page 270, Electrodiagnostic testing is required to eval for carpal tunnel and stratify success in carpal tunnel release. In addition, the guidelines recommend splinting and medications as well as a cortisone injection to help facilitate diagnosis. In this case there is lack of evidence of failed bracing or injections in the records. Therefore the determination is for non-certification. The Official Disability Guidelines were also referenced for more specific recommendations. According to the Official Disability Guidelines regarding surgery for carpal tunnel syndrome, "Recommended after an accurate diagnosis of moderate or severe CTS. Surgery is not generally initially indicated for mild CTS unless symptoms persist after conservative treatment. Severe CTS requires all of the following: Muscle atrophy, severe weakness of thenar muscles, 2-point discrimination test greater than 6 mm and positive electrodiagnostic testing. Not severe CTS requires all the following: Symptoms of pain, numbness, paresthesia, impaired dexterity requiring two of the following: Abnormal Katz hand diagram scores, nocturnal symptoms, Flick sign (shaking hand); findings by physical exam, requiring two of the following including compression test, Semmes-Weinstein monofilament test, Phalen's sign, Tinel's sign, decreased 2-point discrimination, mild thenar weakness, (thumb adduction); comorbidities of no current pregnancy; initial conservative treatment requiring three of the following: Activity modification greater than or equal to one month, night wrist splint greater than or equal to one month, nonprescription analgesia (i.e. acetaminophen), home

exercise training (provided by physician, healthcare provider or therapist) or successful initial outcome from corticosteroid injection trial (optional) and positive electrodiagnostic testing". In this case there is insufficient evidence of carpal tunnel syndrome and failure of conservative management as stated above. There is insufficient evidence of abnormal hand diagram scores, nocturnal symptoms, decreased two point discrimination or thenar weakness to warrant surgery. Therefore the determination is not medically necessary.

**Trial of lumbar spinal cord stimulator using high frequency servo system:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Spinal cord stimulators (SCS).

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines, pages 106-107 states that it is recommended only for selected patients when less invasive procedures have failed or are contraindicated for specific conditions and when there is a successful temporary trial. Those conditions are as stated below. Indications for stimulator implantation: Failed back syndrome (persistent pain in patients who have undergone at least one previous back operation), more helpful for lower extremity than low back pain, although both stand to benefit, 40-60% success rate 5 years after surgery. It works best for neuropathic pain. Neurostimulation is generally considered to be ineffective in treating nociceptive pain. The procedure should be employed with more caution in the cervical region than in the thoracic or lumbar. Complex Regional Pain Syndrome (CRPS)/Reflex sympathetic dystrophy (RSD), 70-90% success rate, at 14 to 41 months after surgery. (Note: This is a controversial diagnosis.) Post amputation pain (phantom limb pain), 68% success rate, Post herpetic neuralgia, 90% success rate-Spinal cord injury dysesthesias (pain in lower extremities associated with spinal cord injury), Pain associated with multiple sclerosis, Peripheral vascular disease (insufficient blood flow to the lower extremity, causing pain and placing it at risk for amputation), 80% success at avoiding the need for amputation when the initial implant trial was successful. The data is also very strong for angina. In this case the exam note from 7/31/15 does not demonstrate any of the above indications as being satisfied or lesser invasive procedures have been attempted. Therefore the determination is not medically necessary.