MAXIMUS Federal Services

Case Number:	CM14-0150061		
Date Assigned:	09/25/2014	Date of Injury:	01/19/2011
Decision Date:	11/05/2014	UR Denial Date:	09/05/2014
Priority:	Standard	Application Received:	09/15/2014

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 Hand Surgeon and is licensed to practice in Oregon. 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 64-year-old female was injured on 1/19/11. The mechanism of injury occurred when she was walking outside a laundry room and she slipped and fell landing on right elbow. The diagnoses included right open carpal tunnel syndrome (CTS) and right cubital tunnel syndrome. The electromyogram/nerve conduction study (EMG/NCS) report on 8/13/12, revealed evidence for right ulnar neuropathy at the elbow with conduction block and slowing of conduction velocity. The X-ray report of the right wrist on 8/15/13, revealed: Probable old traumatic changes to the wrist with degenerative changes seen in the radiocarpal joint; the scaphoid bone appeared to have beenpreviously fractured and now had an abnormal orientation; scapholunate joint appears minimally widened; fusiform bone was displaced proximally. The X-ray report of the right elbow dated 8/15/13, revealed a stable post-operative right elbow. The office visit note on 4/21/14, noted the patient complained of right elbow pain, weakness, loss of motion and ulnar sided numbness. The patient was status post open reduction internal fixation (ORIF) of the right coracoid fracture, radial head replacement and lateral ligament reconstruction on 1/31/11. She received multiple post-op injections for elbow pain and crepitus without significant relief. She then underwent a second procedure of removal of her radial head implant and excision of exogenous bone with some improvement of pain. The examination revealed right elbow active range of motion (AROM), 15-100 degrees for flexion/extension, 75 degrees for supination, 90 degrees for pronation, moderate crepitus with ROM, decreased strength, and decreased two point sensation on the ulnar border, digits had a positive Tinel's sign at the cubital tunnel. The recommendations were for an ulnar nerve release at the cubital tunnel or transposition, and right carpal tunnel release.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right open carpel tunnel release: Upheld

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

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

Decision rationale: The carpal tunnel release is not medically necessary. According to the ACOEM guidelines, Chapter 11, page 270, "Surgical decompression of the median nerve usually relieves CTS symptoms. High-quality scientific evidence shows success in the majority of patients with an electrodiagnostically confirmed diagnosis of CTS. Patients with the mildest symptoms display the poorest post-surgery results; patients with moderate or severe CTS have better outcomes from surgery than splinting. CTS must be proved by positive findings on clinical examination and the diagnosis should be supported by nerve-conduction tests before surgery is undertaken." The nerve conduction test dated 2/6/12 did not show any evidence of carpal tunnel syndrome. Per the ACOEM guidelines, carpal tunnel release is medically necessary.

Right cubital tunnel release: 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): 240.

Decision rationale: The cubital tunnel release is not medically necessary. According to the ACOEM guidelines, Chapter 10 page 240, "Surgery for ulnar nerve entrapment is indicated after establishing a firm diagnosis on the basis of clear clinical evidence and positive electrical studies that correlate with clinical findings. A decision to operate presupposes that a significant problem exists, as reflected in significant activity limitations due to the specific problem and that the patient has failed conservative care, including 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 elbow flexation while sleeping." The records do not document a comprehensive trial of conservative treatment directed specifically toward management of the ulnar nerve compression.

Post-op physical therapy & occupational therapy 2-3x/week for 12 visits: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical therapy Page(s): 16.

Decision rationale: MTUS supports up to 20 visits for OT following cubital tunnel release, but in this case, surgery is not approved and therefore the requested therapy is not necessary.