

<b>Case Number:</b>	CM13-0012674		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	04/18/2011
<b>Decision Date:</b>	02/28/2014	<b>UR Denial Date:</b>	08/07/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/12/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 physician 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:

53 year old female with industrial injury 4/18/11. Exam note 7/17/13 demonstrates nonspecific tenderness. Report of positive Tinel's over cubital tunnel and carpal tunnel. Circumferential numbness about elbow and wrist. No attached Electromyography (EMG) /Nerve Conduction Velocity (NCV) report.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flexor Muscle Slide procedure with Cubital and Carpal Tunnel Releases, Left Wrist and Elbow:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM.

**Decision rationale:** According to the CA MTUS/ ACOEM guidelines 2nd edition states, 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. Before proceeding with surgery, patients must be apprised of all possible complications, including wound infections, anesthetic complications, nerve damage, and the high possibility that surgery will not relieve symptoms. Absent findings of severe neuropathy such as muscle wasting, at least 3-6 months of conservative care should precede a decision to operate. In this clinical scenario there is lack of documentation of evidence on cubital tunnel syndrome correlating with any EMG/NCV testing and therefore is non-certified. Carpal Tunnel Per the CA MTUS/ACOEM guidelines, Chapter 11 Forearm, Wrist and Hand Complaints 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 postsurgery 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. Mild CTS with normal electrodiagnostic studies (EDS) exists, but moderate or severe CTS with normal EDS is very rare. Positive EDS in asymptomatic individuals is not CTS. Studies have not shown portable nerve conduction devices to be effective diagnostic tools. Surgery will not relieve any symptoms from cervical radiculopathy (double crush syndrome). Likewise, diabetic patients with peripheral neuropathy cannot expect full recovery and total abatement of symptoms after nerve decompression. CTS may be treated for a similar period with a splint and medications before injection is considered, except in the case of severe CTS (thenar muscle atrophy and constant paresthesias in the median innervated digits). Outcomes from carpal tunnel surgery justify prompt referral for surgery in moderate to severe cases, though evidence suggests that there is rarely a need for emergent referral. Thus, surgery should usually be delayed until a definitive diagnosis of CTS is made by history, physical examination, and possibly electrodiagnostic studies. Symptomatic relief from a cortisone/anesthetic injection will facilitate the diagnosis;

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