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| **Case Number:** | CM13-0016594 | | |
| **Date Assigned:** | 11/06/2013 | **Date of Injury:** | 12/18/2006 |
| **Decision Date:** | 01/17/2014 | **UR Denial Date:** | 07/31/2013 |
| **Priority:** | Standard | **Application Received:** | 08/26/2013 |

## 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 General Surgery, was fellowship trained in Hand Surgery, and is licensed to practice in Texas and 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:

This patient is a 66-year-old male with multiple listed dates of injury. Notes indicate that the patient is status post endoscopic carpal tunnel release on the right on 4/27/10, and left endoscopic carpal tunnel release on 1/20/11. Notes indicate that the patient initially had resolution of paresthesias; however, the patient's paresthesias have recurred. Notes indicate that the patient has undergone electrodiagnostic studies as of 4/18/13, which demonstrate that the patient has severe bilateral median sensory neuropathy at the wrist, and severe bilateral ulnar sensory neuropathy at the elbows, with very mild bilateral median motor neuropathy at the wrist. Physical examination of the patient details decreased sensation to light touch in the median nerve distribution of the bilateral hands, as well as the ring and small fingers of both hands. The patient has no demonstrated atrophy on physical exam at the first dorsal interosseous muscles bilaterally, or the thenar muscles bilaterally. The patient had positive Tinel's sign of the right greater than the left cubital tunnels; and positive elbow flexion test, right greater than left. Well-healed scars were noted at the wrist flexion creases bilaterally. Recommendation was made for a final revision open median nerve neurolysis with flexor tenosynovectomy at the right wrist, and concomitant right carpal tunnel release in situ, with possible anterior subcutaneous transposition of the ulnar nerve.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**The request for concomitant right cubital tunnel release in situ and the possible anterior subcutaneous transposition of the ulnar nerve:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): s 45-47, 270. Decision based on Non-MTUS Citation Official Disability Guidelines for carpal tunnel syndrome

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 45. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow Chapter, Cubital Tunnel Release.

**Decision rationale:** The California MTUS/ACOEM guidelines state that referral for surgical consultation may be indicated for patients who have significant limitations of activity for more than 3 months; who have failed to improve with exercise programs to increase range of motion and strength of the musculature around the elbow; or who have clear clinical and electrophysiologic or imaging evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. 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. The documentation submitted for review indicates that the patient has electrodiagnostic studies demonstrating severe bilateral median sensory neuropathy at the wrists, as well as severe bilateral ulnar sensory neuropathy at the elbows and mild bilateral median motor neuropathy at the wrists. Notes indicate that the patient has a history of prior bilateral endoscopic carpal tunnel releases; however, the patient has had recurrent paresthesias. While physical examination of the patient demonstrates decreased sensation to light touch in the median nerve distribution to the bilateral hands, as well as the ring and small fingers of both hands, with a positive Tinel's sign of the right greater than left cubital tunnels, and positive elbow flexion test right greater than left, there is a lack of documentation indicating that the patient has completed any of the recommended conservative treatments prior to the request for surgery, which includes full compliance in therapy, use of elbow pads, work station changes, and avoidance of nerve irritation at night by preventing prolonged elbow flexion while sleeping, with the use of padding/splinting. Given the above, the request for concomitant right cubital tunnel release in situ, possible anterior subcutaneous transposition of the ulnar nerve is not medically necessary and appropriate.