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| **Case Number:** | CM13-0046419 | | |
| **Date Assigned:** | 01/10/2014 | **Date of Injury:** | 01/25/2013 |
| **Decision Date:** | 03/26/2014 | **UR Denial Date:** | 11/04/2013 |
| **Priority:** | Standard | **Application Received:** | 11/12/2013 |

## 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 Texas. 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:

The patient is a 41-year-old female who reported injury on 01/25/2013. The specific mechanism of injury was not provided. The patient's diagnoses were noted to include bilateral carpal and cubital tunnel syndrome and left shoulder tendonitis. The patient had a nerve conduction study on 06/10/2013 which revealed a left median nerve and ulnar nerve conduction study that was normal. An EMG of the musculature of the left upper extremity and hand were normal. The patient had an EMG and an NCV of the right upper extremity on 07/03/2013, which revealed the ulnar nerve conduction and the median nerve conduction were normal and the EMG indicated that study was normal as well. The patient was noted to have subjective complaints of significant pain in the elbows with numbness and tingling going to the fingers and weakness of both hands. The patient additionally was complaining of pain from the neck radiating down to the arm. The patient examination revealed the patient had a positive Tinel's, Phalen's and Durkan's over the bilateral wrists. There was noted to be evidence of thenar and hypothenar atrophy. The patient's 2-point discrimination over the median and ulnar nerves were approximately 7 mm and there was bilateral positive Tinel's over the medial epicondyles and positive bilateral elbow flexion texting. The treatment plan was noted to include the patient failed all conservative measure and had a temporary response to a steroid injection to bilateral cubital tunnels and additionally the patient's carpal tunnel syndrome was recently confirmed by a QME. The request was made for bilateral carpal and cubital tunnel releases.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral carpel tunnel releases:** 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- 271. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome Chapter, Carpal tunnel release surgery (CTR)

**Decision rationale:** California MTUS Guidelines indicate that a hand surgery consultation is appropriate for patients who have red flags of a serious nature, have failure to respond to conservative management including work site modifications, have clear and special study evidence of a lesion that has been shown to benefit in both the short and long term from a surgical intervention. Carpal tunnel syndrome must be proved by positive findings on clinical examination and the diagnosis should be supported by nerve conduction test before surgery is undertaken. It further indicates that mild carpal tunnel syndrome with normal electrodiagnostic studies exist but moderate or severe carpal tunnel syndrome with normal electrodiagnostic tests is very rate. As California ACOEM Guidelines do not specifically address criterion for a carpal tunnel release, secondary guidelines were sought. Official Disability Guidelines indicate that for severe carpal tunnel syndrome a patient should have symptoms and findings including muscle atrophy, and severe weakness of the thenar muscles as well as a 2-point discrimination test greater than 6 mm and positive electrodiagnostic testing. For note severe carpal tunnel syndrome there should be all of the following including symptoms, pain, numbness, paresthesia, impaired dexterity, including a Flex sign, nocturnal symptoms and abnormal Katz hand diagrams, physical examination of a positive Phalen's and Tinel's with mild thenar weakness, and initial conservative treatment including activity modification greater than 1 month, night wrist splint greater than 1 month, and nonprescription analgesia or a successful initial outcome from corticosteroid injection trial and positive electrodiagnostic testing. Clinical documentation submitted for review failed to indicate the patient had positive electrodiagnostic testing. The patient had thenar and hypothenar atrophy and the 2-point discrimination over the median and ulnar nerves was approximately 7 mm. There is a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. Given the above, the request for bilateral carpal tunnel release is not medically necessary.

**bilateral cubital tunnel releases:** 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): 25-26.

**Decision rationale:** California MTUS Guidelines indicate that a hand surgery consultation is appropriate for patients who have red flags of a serious nature, have failure to respond to conservative management including work site modifications, have clear and special study evidence of a lesion that has been shown to benefit in both the short and long term from a

surgical intervention. Ulnar nerve entrapment including cubital tunnel syndrome should be diagnosed with a nerve conduction study. Clinical documentation submitted for review failed to indicate the patient had objective findings per the nerve conduction study to support cubital tunnel syndrome. Given the above, the request for two bilateral cubital tunnel releases is not medically necessary.