

<b>Case Number:</b>	CM15-0149332		
<b>Date Assigned:</b>	08/12/2015	<b>Date of Injury:</b>	03/23/2015
<b>Decision Date:</b>	10/08/2015	<b>UR Denial Date:</b>	07/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/31/2015

### 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: Maryland, Virginia, North Carolina  
 Certification(s)/Specialty: Plastic 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:

The injured worker is a 65-year-old male who sustained a cumulative industrial injury on 03-23-2015. The injured worker was diagnosed with bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome. According to the primary treating physician's progress report on June 26, 2015, the injured worker continues to experience bilateral wrist symptoms with progressive right hand numbness, pain and tingling with an enlarging right wrist dorsal ganglion cyst. The injured worker is eager to proceed with surgery on the right hand. Prior treatments documented to date have included rest, modified activities, wrist brace, therapy with minimal or no benefit, aspiration of the right ganglion cyst with temporary relief then re-accumulation of fluid and medications. Examination demonstrated a right ganglion mass, tenderness of the right wrist and wrist extensor tendons. Muscle strength testing noted right wrist flexion and grip within normal limits and extension at 4 out of 5 with decreased sensation at the median and ulnar nerve. Distal sensation, pulses and deep tendon reflexes were intact. Tinel's, Phalen's and carpal tunnel compression tests were positive on the right. No thenar atrophy was present. Finger abduction was within normal limits. Right elbow range of motion was full and symmetric with a negative Tinel's at the elbow. The provider documented "altered sensation is reported throughout the right although discrimination is intact and the radial nerve sensation is intact throughout the hand". According to a medical record dated March 16, 2015, an Electromyography (EMG) and Nerve Conduction Velocity (NCV) performed on March 4, 2015 revealed "moderate bilateral carpal tunnel syndrome and mild bilateral ulnar nerve entrapment" and a magnetic resonance imaging (MRI) performed on March 31, 2015 revealed "a 1st carpometacarpal osteoarthritis, four loose

bodies, full thickness right wrist triangular fibrocartilage complex (TFCC) tear". Current medications were listed as Norco and Pantoprazole. On June 29, 2015, the provider requested authorization for a right carpal tunnel release and right cubital tunnel release. The Utilization Review determined the request for the above intervention was not medically necessary on 07-02-2015.

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

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

**Right cubital tunnel release:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 18 19 27.

**Decision rationale:** The patient is a 65-year-old male with signs and symptoms of a possible right cubital tunnel syndrome. He has some diminished sensation in the ulnar nerve distribution, but has a negative Tinel's at the elbow. Electro diagnostic studies support a mild condition. Documented conservative management has included NSAIDs, activity modification and therapy. The time course of this management is unclear from the documentation. From ACOEM, Chapter 10, page 18 and 19, the following is stated with respect to cubital tunnel syndrome: Aside from surgical studies, there are no quality studies on which to rely for treatment of ulnar neuropathies, and there is no evidence of benefits of the following treatment options. However, these options are low cost, have few side effects, and are not invasive. Thus, while there is insufficient evidence, these treatment options are recommended: Elbow padding [Insufficient Evidence (I), Recommended]; Avoidance of leaning on the ulnar nerve at the elbow [Insufficient Evidence (I), Recommended]; Avoidance of prolonged hyperflexion of the elbow [Insufficient Evidence (I), Recommended]; and Although not particularly successful for neuropathic pain, utilization of NSAIDs [Insufficient Evidence (I), Recommended]. From page 27, "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." Based on these recommendations, the patient has not satisfied a comprehensive course of conservative management, including use of elbow pads, and avoidance of prolonged elbow flexion while sleeping. As there are no signs of severe neuropathy, this should be documented over a 3-6 month period. Therefore, right cubital tunnel release should not be considered medically necessary.

**Right carpal tunnel release:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272.

**Decision rationale:** The patient is a 65-year-old male with signs and symptoms of possible right carpal tunnel syndrome that has failed some conservative management. Electro diagnostic studies support that there is a moderate carpal tunnel syndrome present. Clinically, there are no signs of a severe condition that could include but not limited to thenar atrophy. Therefore, recommended conservative management should be fully documented. From Chapter 11, page 272, injection of corticosteroids into the carpal tunnel is recommended in mild to moderate cases of carpal tunnel syndrome after trial of splinting and medication. As consideration for a steroid injection has not been documented and that the patient has evidence of a moderate condition, right carpal tunnel release should not be considered medically necessary.