

<b>Case Number:</b>	CM15-0074135		
<b>Date Assigned:</b>	04/24/2015	<b>Date of Injury:</b>	08/21/2013
<b>Decision Date:</b>	05/21/2015	<b>UR Denial Date:</b>	03/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/17/2015

### 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 40-year-old female, who sustained an industrial injury on August 21, 2013. She reported numbness, tingling and pain in the left upper extremity, elbow and hand. The injured worker was diagnosed as having chronic left cubital tunnel syndrome and carpal tunnel syndrome, status post right cubital tunnel release and ulnar nerve decompression at the wrist, bilateral medial epicondylitis, bilateral forearm tendinitis, right lateral epicondylitis and trapezial and paracervical strain. Treatment to date has included radiographic imaging, electrodiagnostic studies, surgical intervention of the right upper extremity, conservative care, medications and work restrictions. Currently, the injured worker complains of left upper extremity pain, weakness, numbness and tingling. The injured worker reported an industrial injury in 2013, resulting in the above noted pain. She was treated conservatively and surgically without complete resolution of the pain. Evaluation on February 19, 2015, revealed continued pain with associated symptoms as noted. Left cubital tunnel release and carpal tunnel release were requested. The requesting surgeon notes that there is a false negative rate of 20% with normal electrodiagnostic studies. Previous electrodiagnostic studies were reported as normal. Previous AME from noted surgical treatment for the left elbow is reasonable.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left cubital tunnel release and carpal tunnel release: Upheld**

**Claims Administrator 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 (ODG), Elbow.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261, 270, and 272.

**Decision rationale:** The patient is a 40-year-old female with signs and symptoms of a possible left carpal tunnel syndrome that has failed conservative management of splinting, NSAIDs, physical therapy and activity modification. Electrodiagnostic studies are reported to be normal. The requesting surgeon notes that a false negative rate is present of 20% with normal EDS studies. From ACOEM, page 270, Chapter 11, 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. Mild CTS with normal electrodiagnostic studies (EDS) exists, but moderate or severe CTS with normal EDS is very rare. In addition, from page 272 recommendations are made for a consideration for a steroid injection after initial treatment with splinting and NSAIDs. There is insufficient evidence from the medical record that there is a severe carpal tunnel syndrome. Therefore, conservative management including a consideration for a steroid injection should be completed. Splinting and NSAIDs have been documented, but not a steroid injection. Given the normal EDS studies, a positive response from a steroid injection may help to facilitate the diagnosis. Without this response, repeat EDS can be considered. As stated from page 261, 'If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist.' Therefore, left carpal tunnel release is not medically necessary.