

Independent Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 24, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Neuroplasty, Major peripheral nerve, Arm or leg

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Board Certified Orthopedic Surgeon

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Neurological Consult, Dr., 04/23/07

EMG/NCV, 04/23/07

Office note, Dr. 08/9/07

Peer reviews, 08/16/07, 09/04/07

No ODG Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who complained of right upper extremity symptoms on .Her history is significant for previous bilateral carpal tunnel release surgery as well as left ulnar nerve release at the elbow. She treated with anti-inflammatory medication, physical therapy and cortisone injection which provided temporary relief. A request was

made for authorization of a right upper extremity extensor origin release, partial lateral epicondylectomy and radial tunnel release.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

This is a female who reportedly suffered from extensor origin syndrome of the right elbow in conjunction with radial tunnel syndrome. The Reviewer has reviewed the clinical information provided. The Reviewer would submit that this individual, does have findings consistent with the diagnosis of extensor origin syndrome, i.e., lateral epicondylitis and also, based on examination findings including tenderness over the radial tunnel and resisted long finger extension that the clinical diagnosis of radial tunnel would also be apparent. Electromyograms, although reportedly negative, are not commonly diagnostic in this particular malady.

Records also, document sufficient conservative treatment including anti-inflammatories, physical therapy, activity modification and corticosteroid injection. The fact that corticosteroid injection offered relief for one month would be diagnostic for the component of lateral epicondylitis. As such, the Reviewer would disagree with the previous reviewers that stated that this individual has not failed conservative treatment or does not meet ODG criteria. While most individuals will recover from lateral epicondylitis with conservative measures, it appears as though this individual had been through seven months of conservative treatment and had thus, failed sufficient conservative measures in order to proceed with surgical intervention as outlined.

Official Disability Guidelines Treatment in Workers' Comp 2007 Updates: Elbow

Surgery for Cubital Tunnel Syndrome:

Recommended as indicated below (simple decompression). Surgical transposition of the ulnar nerve is not recommended. Surgery for ulnar neuropathy at the elbow is effective two-thirds of the time. The outcomes of simple decompression (SD) and anterior subcutaneous transposition (AST) are equivalent, except for the complication rate, which is 31% in AST. Because the intervention is simpler and associated with fewer complications, SD is advised, even in the presence of (sub)luxation. (Bartels, 2005) (Asamoto, 2005) (Lund, 2006) (Nabhan, 2007) Although clinically equally effective, simple decompression was associated with lower cost than anterior subcutaneous transposition for the treatment of ulnar neuropathy at the elbow. The main difference was in the costs related to sick leave, which is significantly shorter for simple decompression. (Bartels2, 2005) (Nabhan, 2005) Simple decompression may offer excellent intermediate and long-term relief of symptoms. Less complete relief of symptoms following ulnar nerve decompression may be related to unrecognized carpal tunnel syndrome or weight gain. (Nathan, 2005) Medial epicondylectomy for persons with cubital tunnel syndrome was superior to anterior transposition in relieving pain and in improving global outcome scores. Patients whose cubital tunnel syndrome is caused by an acute trauma have better outcomes after surgical treatment than patients with cubital tunnel syndrome from other causes. (AHRQ, 2002) Partial medial epicondylectomy seems to be safe and reliable for treatment of cubital compression neuropathy at the elbow. (Efsthopoulos, 2006) One study reviewed the results of two

surgical methods for treating cubital tunnel syndrome. From 1994 to 2001, minimal medial epicondylectomy was performed on 22 elbows, and anterior subcutaneous transposition of the ulnar nerve was done on 34 elbows. In the group treated by medial epicondylectomy, 9 of the results (41%) were excellent, 10 (45%) were good, 2 (9%) were fair, and 1 result (5%) was poor. In the group treated by anterior subcutaneous transposition of ulnar nerve, 14 of the results (41%) were excellent, 13 (38%) were good, 6 (18%) were fair, and 1 result (3%) was poor. No significant difference was found between the 2 groups ($P < .05$). (Baek, 2005) (Greenwald, 2006) Age at surgery, duration of cubital tunnel syndrome, preoperative severity, and clinical symptom score and motor nerve conduction velocity in the early postoperative stage (one month after surgery) were found to be important prognostic factors of the syndrome. (Yamamoto, 2006)

ODG Indications for Surgery -- Simple Decompression (SD) for cubital tunnel syndrome: Initial conservative treatment, requiring ALL of the following:

- Exercise: Strengthening the elbow flexors/extensors isometrically and isotonicly within 0-45 degrees
- Activity modification: Recommend decreasing activities of repetition that may exacerbate the patient's symptoms. Protect the ulnar nerve from prolonged elbow flexion during sleep, and protect the nerve during the day by avoiding direct pressure or trauma.
- Medications: Nonsteroidal anti-inflammatory drugs (NSAIDs) in an attempt to decrease inflammation around the nerve.
- Pad/splint: Use an elbow pad and/or night splinting for a 3-month trial period. Consider daytime immobilization for 3 weeks if symptoms do not improve with splinting. If the symptoms do improve, continue conservative treatment for at least 6 weeks beyond the resolution of symptoms to prevent recurrence.

Surgery for Epicondylitis:

Under study. Almost all patients respond to conservative measures and do not require surgical intervention. Treatment involves rest, ice, stretching, strengthening, and lower intensity to allow for maladaptive change. Any activity that hurts on extending or pronating the wrist should be avoided. With healing, strengthening exercises are recommended. Patients who are recalcitrant to six months of conservative therapy (including corticosteroid injections) may be candidates for surgery. There currently are no published controlled trials of surgery for lateral elbow pain. Without a control, it is impossible to draw conclusions about the value of surgery. Generally, surgical intervention may be considered when other treatment fails, but over 95% of patients with tennis elbow can be treated without surgery. (Buchbinder-Cochrane, 2002) (California, 1997) (Pilgian, 2000) (Foley, 1993) (AHRQ, 2002) (Theis, 2004) (Jerosch, 2005) (Balk, 2005) (Sennoune, 2005) (Szabo, 2006) Disappointing results of surgery were found in litigants with epicondylitis. (Kay, 2003) (Balk, 2005) Surgery is not very common for this condition. In workers' compensation, surgery is performed in only about 5% cases

AAOS Orthopaedic Knowledge Update, Shoulder and Elbow 2. Chapter 29, p. 300

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE
 - AAOS Orthopaedic Knowledge Update, Shoulder and Elbow 2. Chapter 29, p. 300
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)