

# P&S Network, Inc.

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**DATE OF REVIEW:** September 18, 2008

**IRO CASE #:**

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

This case was reviewed by an orthopedic surgeon, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

## **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

NCV of the right upper extremity

## **REVIEW OUTCOME**

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

Overtured (Disagree)

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o August 7, 2008 utilization review report from, Inc.
- o August 18, 2008 utilization review report from, Inc.
- o August 7, 2008 letter
- o August 18, 2008 letter
- o February 12, 2008 through April 10, 2008 records from Clinic Ortho

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical records, the patient sustained an industrial injury on xx/xx/xx. An August 7, 2008 utilization review report states that the patient had a work injury when he was pushing a heavy weight and heard a pop in his shoulder. He has felt paresthesias with reduced sensation in the ulnar distribution since that time. The report states that an examination of the elbow was not performed. He had intact strength and sensation per the notes. He had not undergone splinting or other treatment for the elbow. There has been persistent reduced subjective sensation in the ulnar digits since the injury. The physician reviewer rendered a non-certification as there was no examination of the elbow. The report states that the patient has had inadequate conservative care for the elbow and no full exam. The patient should have a trial of splinting for four weeks and an exam prior to further consideration according to the letter.

The case was again reviewed on August 18, 2008 and another non-certification rendered. The report notes that the patient is a XX-year-old male who has been on lifting restrictions for his shoulder pain. He has had no physical therapy. He reports no neck pain and no radiation, but has paresthesias in the right hand in the ulnar nerve distribution. Examination findings included muscle strength 5/5, decreased C7 sensation on the right, symmetric reflexes, crisp capillary refill bilaterally, and other findings regarding the shoulder. Plain radiographs of the right shoulder were normal. Examination on April 10, 2008 showed only slight improvement with internal and external rotation. An MRI of the right shoulder reportedly showed hypertrophy of the acromioclavicular joint, tendinitis of the supraspinatus, and possible labral tear. A new finding of cubital tunnel syndrome was noted, but examination of the right elbow and forearm revealed no tenderness and no pain with percussion over the cubital tunnel or Guyon's canal. Range of motion of the right elbow was reported to be functional. The peer review report rendered a non-certification as there was no comprehensive history of conservative treatment today. It was also noted that there was no

objective evidence of cubital tunnel syndrome with only subjective complaints documented.

In reviewing the February 12, 2008 orthopedic report, the patient did report paresthesias in the right hand in the ulnar distribution.

A review of the examination findings confirms those as outlined above with the addition of decreased sensation in the ulnar distribution of the right hand. The patient was again examined on April 10, 2008 and he complained of numbness of his right third through fifth fingers clinically consistent with cubital tunnel syndrome. Decreased sensation over the ulnar nerve distribution of the hand was again noted. The physician stated that he will try to get a nerve study approved. If it is abnormal, he will perform an ulnar nerve transposition at the time of the shoulder surgery.

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

According to the Official Disability Guidelines, one test for cubital tunnel syndrome, ulnar motor nerve conduction velocity at the elbow, is reported to have high specificity and low sensitivity. Insufficient data exists to allow firm evidence-based conclusions regarding the effectiveness of any tests for cubital tunnel syndrome, as the evidence base is small and heterogeneous. An electromyography (EMG) is not essential when the diagnosis of cubital tunnel syndrome is obvious on clinical examination, as a false test result can be misleading.

The patient demonstrates clinical signs consistent with possible cubital tunnel syndrome. The request for an electrodiagnostic study is absolutely indicated and related to the original injury. Therefore, my determination is to overturn the previous decisions to non-certify the request for electrodiagnostic testing of the right upper extremity.

The IRO's decision is consistent with the following guidelines:

**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 (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME

Official Disability Guidelines (2008)/Elbow Chapter:

Tests for cubital tunnel syndrome (ulnar nerve entrapment)

Under study. One test for cubital tunnel syndrome, ulnar motor nerve conduction velocity at the elbow, is reported to have high specificity and low sensitivity. Insufficient data exists to allow firm evidence-based conclusions regarding the effectiveness of any tests for cubital tunnel syndrome, as the evidence base is small and heterogeneous. Diagnosis may be made by symptoms. The elbow is the most common site of compression of the ulnar nerve. Cubital tunnel syndrome is the second most common compressive neuropathy (after carpal tunnel syndrome). Cubital tunnel syndrome affects men 3-8 times as often as women. Affected patients often experience numbness and tingling along the little finger and the ulnar half of the ring finger. This discomfort often is accompanied by weakness of grip. An electromyography (EMG) is not essential when the diagnosis of cubital tunnel syndrome is obvious on clinical examination, as a false test result can be misleading. (AHRQ, 2002) (Lo, 2005) (Robertson, 2005) See also Surgery for cubital tunnel syndrome. The incidence of ulnar nerve entrapment at the elbow (overall 0.8%) is associated with one job related risk factor (holding a tool in position, repetitively, with an odds ratio of 4.1), plus obesity (4.3) and other upper-limb work-related musculoskeletal disorders, especially medial epicondylitis and other nerve entrapment disorders (cervicobrachial neuralgia and carpal and radial tunnel syndromes). (Descatha, 2004) Cubital tunnel syndrome (entrapment of the ulnar nerve at the elbow) is the second most common peripheral nerve entrapment syndrome in the human body, after carpal tunnel syndrome. Patients who are affected with cubital tunnel syndrome often experience numbness and tingling along the little finger and ulnar half of the ring finger, usually accompanied by weakness of grip. This frequently occurs when the patient rests upon or flexes the elbow. When appropriately diagnosed, this condition may be treated by both conservative and operative means. (Cutts, 2007)