

# P&S Network, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 01/26/2009

**IRO CASE #:**

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

This case was reviewed by a Orthopaedic Surgery, 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**

Left ulnar nerve transposition

### **REVIEW OUTCOME**

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

**Upheld (Agree)**

### **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 May 9, 2008 Pre-op History and Physical from Dr.
- o May 15, 2008 Lumbar x-ray report read by Dr.
- o May 15, 2008 Final Report from Dr.
- o July 15, 2008 Follow-up examination report from Dr.
- o August 13, 2008 Certification letter for Cervical CT Myelogram request
- o October 14, 2008 Follow-up examination report from Dr.
- o November 18, 2008 Letter of non-certification for request for left ulnar nerve transposition
- o November 26, 2008 Letter of non-certification for request for reconsideration for left ulnar nerve transposition
- o January 7, 2009 Request for IRO

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

According to the medical records submitted for review, the patient is a xx-year-old employee who sustained an industrial injury to the low back on xx/xx/xx associated with a rear-end impact motor vehicle accident. The patient was treated for low back pain radiating to the left posterior thigh and knee with some subjective weakness. As conservative treatments failed to resolve his condition, he was considered for surgery.

The pre-op history and physical report of May 9, 2008 indicates the patient has persisting headaches and low back pain since the MVA of 7 months prior. He has attempted treatments of pain relievers, muscle relaxants and anti-inflammatory medications. Imaging has shown interval enlargement of a posterior central left paracentral disc herniation at L5-S1 with moderate to severe mass effect upon the ventral lateral aspect of the thecal sac and S1 descending nerve root on the left. The patient was cleared for surgery.

The patient underwent surgery on May 15, 2008 described as left L5-S1 hemilaminectomy, medial facetectomy and foraminotomy with discectomy. It was noted that the patient had undergone a previous surgery in the same area.

The patient was examined two weeks post-operative on May 30, 2008 and noted to be doing well. The surgical staples were

removed. The patient returned on July 15, 2008. The patient underwent cervical MRI which shows mild to moderate neuroforaminal stenosis at C3-4, C4-5 and C6-7. Now that the lumbar condition has been addressed treatment will focus on the cervical condition. He reports continuing posterior neck pain with numbness at the left upper extremity. EMG/NCV shows left ulnar entrapment at the elbow. Recommend a cervical myelogram, CT scan.

The patient was reevaluated next on October 14, 2008. The patient was requested at the prior visit to have a CT myelogram and then follow-up. Imaging shows mild spondylotic changes at C3-4, C4-5 and C6-7 with mild foraminal tenosis. Recommendation is for left ulnar nerve transposition and referral to pain management for trigger point injections to the neck.

Request for left ulnar nerve transposition was not certified in review on November 18, 2008 with rationale that per the literature, 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 complications 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. It was noted that the cervical CT Myelogram results were not clarified and the actual EMG/NCV report was not submitted for review. Physical examination findings to support ulnar nerve compression were not reported.

Request for reconsideration of left ulnar nerve transposition was also not certified in review on November 26, 2008 with rationale that the ODG criteria for this intervention had not been met. The medical records failed to document conservative treatments such as exercise, injections, NSAIDS, use of an elbow pad and/or night splinting for 3 months and specific physical examination findings supporting the diagnosis such as positive compression tests and grip strength and the specific areas of numbness. It was noted that the EMG/NCV finding of ulnar nerve neuropathy was essentially an incidental finding not related to the work place event.

The provider has requested an IRO.

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

The Official Disability Guidelines does not recommend ulnar nerve transposition versus simple decompression due the higher complication rate. As noted, the patient has been treated for a neck and low back injury and the EMG/NCV findings of ulnar nerve entrapment is an incidental finding not corroborated by physical examination findings. The medical records additionally fail to document conservative attempts to treat this condition per guidelines of exercises to strengthen the elbow flexors/extensors, activity modification such as decreasing activities of repetition that might exacerbate the symptoms, protecting the ulnar nerve from prolonged elbow flexion during sleep, and protecting the nerve during the day by avoiding direct pressure or trauma or use of NSAIDs to decrease inflammation around the nerve. Additionally, it is recommended to use an elbow pad and/or night splinting for a 3-month trial period and to consider daytime immobilization for 3 weeks if symptoms do not improve with splinting. Guidelines also recommended to continue conservative treatment for at least 6 weeks beyond the resolution of symptoms to prevent recurrence. Given the lack of support in the guidelines for this intervention, the incidental nature of the finding and failure of the records to document corroborative physical examination findings or conservative measures attempted, this intervention is not recommended. Therefore, my determination is to agree with the previous non-certification of the request for left ulnar nerve transposition.

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

The Official Disability Guidelines Elbow December 23, 2008  
Surgery for Cubital Tunnel Syndrome -Ulnar Nerve Entrapment

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.

