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Notice of Independent Review Decision

DATE OF REVIEW: 03-15-09

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 elbow subcutaneous transposition of ulnar nerve

REVIEW OUTCOME

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

Overtuned (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 September 19, 2008 Medical report from Dr.
- o September 26, 2008 Medical report from Dr.
- o October 24, 2008 Medical report from Dr.
- o December 2, 2008 EMG/NCV report from Dr.
- o December 2, 2008 Referral note for EMG from Dr.
- o December 9, 2008 MR Arthrogram, left elbow as read by Dr.
- o January 6, 2008 Medical report from Dr. I
- o January 8, 2009 Medical report from Dr.
- o January 9, 2009 Medical report from Dr.
- o January 19, 2009 Non-certification report for ulnar nerve transposition
- o February 17, 2009 Non-certification report for reconsideration ulnar nerve transposition
- o February 25, 2009 Request for IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records submitted for review, the patient is a male who sustained an industrial injury to the left elbow on or about xx/xx/xx while tying down straps on his flatbed truck. A strap snapped and hit him in the mouth knocking him to the ground. He broke two teeth and landed on his left elbow. He was initially examined by his current provider on September 19, 2008. The report noted tingling, swelling, numbness and stiffness at the left elbow. The patient described a pain level of 6/10. The patient is 6' 2" and 238 pounds. Tenderness is noted at the medial epicondyle. Elbow x-ray is unremarkable but noted to be suspicious for radial neck non-displaced fracture. The diagnosis is left elbow sprain and medial elbow contusion. A sling was provided and range of motion exercises instructed.

The patient returned on September 26, 2008. He noted improvement in his symptoms with ice, rest, immobilization and NSAIDS. There is tenderness at the medial elbow. Elbow flexion is 110 degrees and extension -30 degrees. He is allowed return to modified duties.

The medical report of October 24, 2008 indicates the patient has a pain level of 2-3/10. Examination shows a normal carrying angle of the left elbow. There is pain at the medial aspect and ulnar border of the forearm and wrist with decreased range of motion perhaps due guarding. He should continue physical therapy as previously prescribed. An MR Arthrogram and EMG of the left upper extremity were ordered.

The patient was examined for electrodiagnostic studies on December 2, 2008. He reports a throbbing sensation and numbness along the palmar side of the left arm, all the way to fingers 4 and 5. He has decreased muscle strength in the forearm muscles, particularly with wrist flexion. Reflexes are intact. The electrodiagnostic studies show findings consistent with carpal tunnel syndrome and left ulnar nerve neuropathy. There was no indication of denervation or cervical root irritation.

MR Arthrogram of December 9, 2008 shows an unremarkable examination. There is no evidence of filling defect of osteochondral lesion. There is nonspecific soft tissue contusion over the posterior medial aspect of the elbow with associated mild strain of the common flexor tendon but without evidence of disruption.

The patient was reevaluated on January 6, 2009. He has had elbow pain for 4 months. No subluxation of the ulnar nerve is detected. Tinel's and carpal tunnel compression are positive. Left cubital tunnel is positive. He is referred to a colleague for further evaluation.

The patient was evaluated on January 8, 2009 at the same clinic. He reports a pain level of 6/10. There is crepitus with elbow flexion and extension. Elbow range of motion is normal. Muscle strength is full. Tinel's is positive. The diagnosis is left elbow sprain and contusion and cubital tunnel syndrome. Prior medical records were reviewed. Lyrica was prescribed. Recommendation is for left subcutaneous transposition of the ulnar nerve.

Request for left elbow subcutaneous transposition of the ulnar nerve was not certified in review on January 19, 2009 with rationale that adequate supporting medical documentation showing the treatment is appropriate was not submitted. It was noted that ODG does not support transposition of the ulnar nerve due to the complication rate as compared to in-situ decompression of the nerve. There was no indication that an elbow pad and/or night splinting had been attempted as required by ODG.

Request for reconsideration for left elbow subcutaneous transposition of the ulnar nerve was not certified in review on February 17, 2009 with rationale that the medical records failed to document exhaustion of the conservative treatment recommended by ODG. It was also noted that ODG recommends simple decompression versus decompression and transposition of the ulnar nerve.

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

ODG recommends conservative treatment including 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, use of an elbow pad and/or night splinting for a 3-month trial period and consideration of daytime immobilization for 3 weeks if symptoms do not improve with splinting. The patient has been provided treatment including Lyrica, a sling, instruction in range of motion exercises, physical therapy, time off work and modified duties.

The patient has been provided a wide variety of conservative treatments and subcutaneous transfer is an acceptable method of treating ulnar neuropathy. Therefore, my determination is to disagree with the previous non-certification of the request for left elbow subcutaneous transposition of the ulnar nerve and overturn the denial.

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 Chapter - Updated 12/23/2008:
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. (Efstathopoulos, 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.