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Notice of Independent Review Decision

DATE OF REVIEW: 09/03/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Left Elbow Cubital Tunnel Release Outpt 64718

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

Texas Board Certified Orthopedic Surgeon

REVIEW OUTCOME

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

Denial Upheld

PATIENT CLINICAL HISTORY (SUMMARY):

The employee was described as a xx year old left hand dominant male. The employee sustained an injury to the left upper extremity localized to his left elbow when he reportedly slipped and attempted to grab onto something with his left upper extremity. The employee could not recall if he lost consciousness for an undetermined period of time following the accident; however, he stated he awoke after the fall with mud on his head and not recalling the exact mechanism of his injury. After his fall, he noticed his left elbow rotated abnormally. He then sought medical attention where he was advised to go to the emergency department.

The employee was seen at Medical Center emergency department where he was evaluated by Dr. The employee was diagnosed with a dislocated left elbow and a chip fracture of the olecranon. No diagnostic reports or results from Medical Center were provided.

In addition to no emergency room evaluations or notes to correlate with objective findings, on 10/01/08, the employee was evaluated by Dr.. There were no evaluation or progress notes included of visitation; however, per report, the employee underwent two x-rays of the left elbow which revealed diffuse soft tissue swelling with chronic osseous density associated with medial epicondylar, most likely related to old trauma.

The notes indicated that the employee was referred to an orthopedist and spine specialist. There was no documentation of initial evaluation or progress notes; however, there were reports that the employee was placed in a left elbow cast for two weeks.

There were prescriptions from Medical Center where the employee was evaluated by, a registered occupational therapist. The employee attended occupational therapy sessions at from 11/17/08 to 12/10/08 totaling an accumulative total of eight visits. On initial evaluation by on 11/17/08, there were reports that the employee had surgery on 09/29/08 to relocate the elbow. However, there was no operative report included in the case file. On initial evaluation, the employee exhibited 40 degrees extension, good strength, motor testing revealed initial value was 0 pounds. There was report on initial evaluation which indicated pain was a limiting factor. Pinching strength exhibited tip pinch two pounds, key pinch 4 pounds, and lateral pinch 4 pounds. The employee was provided with passive and active range of motion exercises during his therapy in addition to a home exercise program, which the employee was compliant at home.

The employee completed occupational therapy on 12/10/08 and made considerable progress. In the final assessment, the employee was tolerating treatment without adverse reaction. The employee's symptoms had improved minimally. The employee was performing home exercise program independently, left elbow active range of motion exhibited flexion to be 90 degrees, and 40 degrees elbow flexion. Left hand grip strength increased from 0 pounds to 1 pound. Left pinch strength decreased from initial value of 4 to current value of 3 pounds.

On 01/08/09, the employee underwent EMG/NCV study. The impression was reported to be a normal study with no evidence of left median, ulnar, or radial neuropathy. The EMG/NCV was read by Dr., who assessed the employee to be exhibiting signs of chronic regional pain syndrome. No report of EMG/NCV or assessment of functional and objective measures was provided in the case file.

There was an operative report from 02/10/09 in which the employee underwent surgery. The surgery was performed by Dr. , and the operation performed involved left elbow ulnar collateral ligament reconstruction. Dr. stated six months after injury stress x-rays were taken of the elbow which exhibited significant ulnar subluxation of the olecranon fossa laterally because of incompetent ulnar collateral ligament. There were additional occupational therapy transcriptions from Medical Center in which the employee was reevaluated by, registered occupational therapist, postoperative on 03/17/09.

The employee attended therapy from 03/17/09 to 03/25/09. On the employee's initial occupational therapy reevaluation, the occupational therapist noted that the employee had undergone an EMG/NCV and an MRI of the left elbow which exhibited left elbow ulnar collateral ligament tear. However, there were no EMG/NCV reports or MRI radiology reports to correlate with this documentation. During the initial occupational therapy evaluation his left elbow flexion was 90 degrees, left elbow extension was -30 degrees. Left grip strength was not tested and pinch strength was not tested. The employee was provided with comprehensive occupational treatment, which included passive and active range of motion in addition to manual therapy to his left elbow as well as moist heat.

The employee's left elbow pain and active range of motion continued to improve through 03/24/2009, where as his left elbow active range of motion was -23 degrees

extension and 110 degrees flexion. Pain was also noted to be improving. However on 03/25/09, the employee presented to Medical Center complaining of increased pain.

There was indication that on 04/29/09, the employee switched physical therapy locations and was evaluated at Physical therapy. The employee continued to proceed with therapy sessions from 04/28/09 to 05/19/09. No physical therapy notes were provided in the case file.

There were two progress notes from Dr.. The employee was seen on 05/21/09 and 06/18/09. On 05/21/09, the employee continued to complain of left elbow sharp pain and numbness; however he stated the physical therapy had helped him with active range of motion. On objective findings, the left elbow incision was closed and intact, no erythema, inflammation, or drainage. There was positive tenderness to the medial epicondyle, positive tenderness at the ulnar nerve, and positive Tinel's at the cubital tunnel. Left elbow flexion was 110 degrees and extension was -15 degrees with moderate pain. No gross instability was noted to valgus stress. However, the assessment was difficult to test due to acute injury and pain. Strength was within normal limits. Sensation along ulnar nerve involved distribution tingling. The employee findings from Dr. included in this plan for employee were to continue therapy and give the nerves some time to rest. If the employee had not improved by the next month, Dr. would consider a repeat ulnar nerve transposition due to the nerve subluxing back posteriorly.

On 06/18/09, progress notes reported the employee continued to complain of left elbow sharp pain and numbness, objective findings included significant pain at the elbow with palpation on the medial side, minimal laxity to stressing of the medial side, but the examination was difficult due to pain with ulnar nerve symptoms. Positive Tinel's at the elbow over the ulnar nerve, significant pain with palpation over the nerve, with tingling of the two ulnar digits were noted. The employee's active range of motion was decreased with -10 degrees of extension and 110 degrees of flexion. Dr. concluded in this plan that it was seen that ulnar collateral ligament was still intact but the ulnar nerve transposition had failed. He stated it to have happened four to five weeks after surgery when the employee felt severe pain when therapy manipulated his arm. A redo ulnar nerve transposition was recommended since the ulnar nerve symptoms had not improved despite two to three months of rest and therapy.

There was a Functional Capacity Evaluation (FCE) report summary from 06/23/09, in which the employee was evaluated by, a registered occupational therapist. The occupational therapist stated that the employee did not meet his reported job lifting requirements for greater than 100 pounds during the evaluation. He was self-limited to numerous activities due to complains of impaired left upper extremity discomfort, as well as the inability to use his left upper extremity for general grasping, dynamic use, effort and consistency were graded as good and indicated by the examinee's heart rate. The remaining findings were consistent with a pain response throughout. It should be noted that employee did not attempt numerous activities due to the left upper extremity's inability to use basic dynamic activity. Left elbow active range of motion was 70 degrees flexion and -10 degrees flexion. Deficits were noted in left elbow active range of motion, left upper extremity tolerance, dynamic activity, left hand manual dexterity, and complaints of left upper extremity discomfort with dynamic activity. Some of the functional objective measurements were the following: static strength knuckle to shoulder the employee exhibited 9 pounds, to knuckle 20 pounds, dynamic lifting capacity above shoulder was not attempted, knuckle to shoulder was not attempted,

shoulder to knuckle 0 pounds. Functional activities such as carrying not attempted. The FCE was requested by Dr.

On 06/29/09, the employee was evaluated by Dr., an orthopedic surgeon. According to the Designated Doctor Evaluation, the employee presented with complaints of left elbow pain of 8/10 that was constant sharp and throbbing with
movement. The employee described discomfort as a stabbing pain. The employee also complained of significant numbness in the fourth and fifth digits of the left hand in additional to tingling. The employee was noted to have numbness in the forearm along the ulnar aspect bridging the distance from the ulnar styloid to the medial epicondyle. During the orthopedic physical examination, the employee was noted to be wearing an elbow brace which was locked at -40 to 80 degrees. A medial 7-8 cm incision was noted to be well-healed with no erythema, inflammation, or drainage. Range of motion was -20 degrees extension and 87 degrees flexion. The employee had 90 degrees of supination and no pronation. Numbness in the fourth and fifth digits were noted, elbow was found to be stable, and varus and valgus stress testing both in extension and 30 degrees of flexion. The neurovascular status was intact, Tinel's was positive at the elbow medially, and significant pain more than proportionate to touch especially in the elbow and ulnar nerve distribution. Radiographic evaluation on 06/29/09 included the left elbow which exhibited two metallic pins and postsurgical changes, no evidence of fracture or dislocation, the contour of the osseous structure was smooth and regular, trabecular pattern was intact, and soft tissue was unremarkable. The impression indicated two metallic pins and postsurgical changes. The left humorous radiographic imaging exhibited no fracture or dislocation, the contour of the osseous structure was smooth and regular, a trabecular pattern was intact, and soft tissue was unremarkable. The left forearm radiographic examination exhibited no gross abnormality and postoperative changes in the left elbow. The diagnostic ultrasound exhibited joint fluid, irregularity of the medial collateral ligament, the ulnar nerve appeared to be intact and had some fluid surrounding it suggestive or neuritis or irritation. Dr. impression stated 1) left elbow dislocation status post reduction in emergency room left elbow ulnar collateral ligament sprain complete rupture status post repair on 02/10/2009 by Dr. along with ulnar nerve transposition per his office notes on 06/18/2009, per operative report. 2) Left ulnar nerve damage, awaiting repeat surgery on ulnar transposition. 3) History of chronic regional pain syndrome left upper extremity secondary to ulnar nerve damage. Dr. determined that the employee had not reached Maximum Medical Improvement (MMI) but was expected to reach MMI on or about 08/28/09. Based on the FCE performed, registered occupational therapist, Dr. determined that the employee would not be able to use his left upper extremity for at least three more months. He was cautioned not to drive because he was taking pain medication, he had chronic regional pain syndrome, and needed two hands to drive or operate any machinery.

As per the Designated Doctors Evaluation of 06/29/09, two views of the left humerus revealed a normal examination. Repeat left elbow scan exhibited extensive subcutaneous edema, particularly medially, suggesting significant medial soft tissue trauma. There were two chronic appearing densities in the soft tissue near the medial epicondyle. There was also no radiology reports included regarding the left elbow, left humorous, or diagnostic testing.
A peer review was performed on 07/01/09 by Dr. an orthopedic surgeon, who expertly provided his opinion regarding whether the employee would benefit more from ulnar nerve transposition versus simple decompression. Dr. disagreed, recommending the ulnar nerve transposition according to ***Official Disability Guidelines*** since simple decompression had less complication with the same outcome and instrumentation.

Therefore, there was no clear rationale from the requesting physician to suggest that the employee would benefit from ulnar nerve transposition versus simple decompression. The procedure was not sufficiently substantiated.

An appeal was filed, and the employee underwent an additional non-certified peer review on 08/05/09. A peer review was completed by Dr., an orthopedic surgeon, in which he provided his expert opinion regarding to proceed with surgical transposition of the ulnar nerve. Based upon the ***Official Disability Guidelines***, Dr. reiterated surgical transposition of the ulnar nerve was not recommended and that surgery for ulnar nerve neuropathy at the end was effective two-thirds of the time. The employee had not received effective postoperative conservative treatment in addition to anti-inflammatory modalities to justify failed conservative treatment. Therefore, the request for surgical transposition of the ulnar nerve was not indicated.

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

The employee was injured on xx/xx/xx after falling over a pipe while at work. The employee suffered a left elbow dislocation and has ongoing issues. He is status post left elbow reduction, left elbow ulnar collateral ligament sprain and complete rupture, status post repair along with ulnar nerve transposition. There is no evidence on EMG of ulnar neuropathy, although no EMG report was included in the medical case file. No ulnar nerve neuropathy per the designated doctor examination; however, no EMG report was included in the case file. The claimant also has an ongoing history of a chronic pain syndrome of left upper extremity.

After reviewing both peer reviews from Dr. and Dr., there is currently insufficient documentation of failed conservative treatment which includes the use of medication, injections, exercises, and activity modifications. Consequently, at this time, based on the ***Official Disability Guidelines***, ulnar nerve transposition is not recommended. Additionally, according to Dr., the ***Official Disability Guidelines*** do not support surgical transposition of the ulnar nerve. ***Official Disability Guidelines*** indicate that the claimant must have failed conservative care. The claimant has only undergone physical therapy postoperatively with no mention of anti-inflammatory.

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

1. **Official Disability Guidelines**, Elbow Chapter, Online Version