

Notice of Independent Review Decision

DATE OF REVIEW:

09/04/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Diagnostic right wrist arthroscopy w/extensor carpal ulnaris release and endoscopic vs open cubital tunnel release.

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

Board Certified Orthopaedic Surgeon/Hand Surgeon

REVIEW OUTCOME

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

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The requested service of right wrist arthroscopy, right Extensor Carpal Ulnaris (ECU) release at the sixth dorsal compartment of the right wrist, and endoscopic vs open right cubital tunnel release is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured individual's date of injury is stated as xx/xx/xx. On 02/26/08, an MR/Arthrogram of the right wrist was performed. The Radiologist reports a central triangular fibrocartilage complex (TFCC) defect near the radial insertion ("...may represent a congenital or degenerative defect.") and states that the extensor compartments are intact.

On 07/21/08 Dr. performs surgery. Dr. is stated in subsequent records to have performed "...ECU synovectomy without release and arthroscopic dorsal wrist debridement and also debrided a TFC central tear..."

On 02/05/09, the Attending Provider's initial office note describes: "...no relief...symptoms have gotten worse...continued dorsal ulnar and dorsoradial pain...swelling about the ECU...paresthesias of the ring and small fingers, worse at night."

"NIDDM"

"...swollen and tender over...ECU...no subluxation...tender over TFC. Positive ulnocarpal grind...pisiform boost..."

"...Tinel's sign over the cubital tunnel. Positive elbow flexion test."

"injected...lidocaine and steroid into the 6th dorsal compartment...all ulnar sided pain was resolved, including any pain about the TFC...injected...radiocarpal joint...3-4 portal...pain was resolved

completely...”

On 02/16/09 a nerve conduction study/electromyogram (NCS/EMG) is performed. “Findings c/w generalized sensorimotor neuropathy, superimposed ulnar neuropathy cannot be excluded.”

On 03/05/09 the Attending Provider’s office note states “The injections rendered her totally asymptomatic for 3 weeks. About a week ago, it started to come back...splint is very helpful.”
“Equal sensation to light touch between the index and small...APB and intrinsic abductors...5/5...”
“Tinel’s...negative over the cubital tunnel.”
“{ECU} is nontender...”
“...scapholunate articulation...dorsiflex...significant...pain...”
“...dorsal and ulnar {TFCC} are nontender.”

On 04/03/09 the Attending Provider’s office note states “When she bends her elbow, she gets paresthesias to the ring and the small finger.”
“...ECU...tender...does not have...instability...dorsal and ulnar...{TFCC} are nontender. The ulnocarpal grind test is negative...no pain...at the extremes of forearm pronation or supination...very tender over the scapholunate articulation.”
“Decreased sensation to light touch over the small finger compared to the index...two-point discrimination is 5mm for the small...and 4mm for the index.....4-/5 intrinsic abduction strength.

There is no atrophy of the hand...Negative Tinel’s sign over the cubital tunnel . Positive elbow flexion test, which reproduces her nerve symptoms.”
“For the wrist, she has had a dorsal debridement and she probably has an underlying scapholunate ligament issue. (Reviewer’s note: the MRI was reportedly normal 02/26/08.) I will do a diagnostic arthroscopy and I may debride some things, but I probably will not do anything that is going to be very helpful for her dorsal wrist pain other than try to come up with a diagnosis, which she understands.”

On 04/15/09 , the Attending Provider’s letter states “...asking for authorization for a diagnostic wrist arthroscopy with extensor carpi ulnaris (ECU) release, as well as endoscopic versus open cubital tunnel release.”
{prior} “...ECU surgery without release...continued dorsal ulnar wrist pain...improved by diagnostic injection...has also had splinting...and has failed nonoperative management.”
“...status post arthroscopic dorsal capsulitis debridement, which was not helpful...done by another surgeon...{arthroscopy} would be helpful...to ascertain additional sources of possible intra-articular pain.”
“...cubital tunnel syndrome...superimposed neuropathy...paresthesias radiating from the cubital tunnel to the ring and small fingers...worse with elbow flexion. Provocative signs...positive.”
“All lower levels of care have been exhausted, specifically activity modification, splinting and injections...only provided temporary significant relief and her symptoms have recurred.”

On 05/08/09, the Attending Provider’s office note opines that: “It is very unusual that the sheath was not released on the first surgery and this, obviously, is contributing to her problem...”
“...tender and swollen over the ECU and has pain with resisted extension.”
“...cubital tunnel has a positive Tinel’s sign and positive carpal compression test. ...equal and symmetric muscle tone bilaterally.”

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND

CONCLUSIONS USED TO SUPPORT THE DECISION.

In regards to the requested service of right wrist arthroscopy, ODG-Treatment contains no recommendations (8); therefore according to Texas Labor Code Sec. 137.100 (9), preauthorization is required. The injured individual has already had an arthroscopic debridement (07/21/08) addressing all the abnormal findings of the MR Arthrogram (02/06/08) without relief of pain. No subsequent diagnostic studies are in the records available for review to establish new or additional intra-articular pathology or to support the Attending Provider's suspicion of scapholunate ligament pathology. A single intra-articular cortisone injection has been performed with several weeks of relief. Trials of Physical Therapy and NSAID have not been documented. In his 04/03/09 office note, the Attending Provider is skeptical of the prognosis for relief of pain or return to functional activities following this requested procedure: "...I may debride some things, but I probably will not do anything that is going to be very helpful for her dorsal wrist pain other than try to come up with a diagnosis..." The most-recent medical literature on wrist arthroscopy does not support the usefulness of arthroscopy for that purpose: "Although wrist arthroscopy can identify an anatomic abnormality, it cannot be used to differentiate between an asymptomatic degenerative condition versus a pathologic lesion that is the cause of wrist pain." (7). In the absence of additional documented pathology, no further intra-articular surgery should be considered for the right wrist.

Regarding the requested service of right ECU release, ODG-Treatment contains no recommendations (8); therefore according to Texas Labor Code Sec. 137.100 (9), preauthorization is required. The injured individual has already had a prior ECU synovectomy without release, without relief of pain or swelling. A Medline search for "extensor carpi ulnaris tendonitis treatment" produced only two relevant citations in the last ten years. Both citations were uncontrolled case series which were not helpful in determining the usefulness of ECU tendon release after unsuccessful tenosynovectomy. Green's Operative Hand Surgery Online (1), an authoritative, extensively-referenced and frequently updated standard text, states that other coexisting conditions may be present such as tenosynovitis of other dorsal compartments, Distal Radioulnar Joint (DRUJ) degenerative disease and carpal tunnel syndrome. All of the above have been ruled out by MRI and nerve conduction studies. Recommended nonsurgical care includes splinting (done), NSAIDs (not documented), and cortisone injection (done). Failing improvement with nonsurgical care, Green's recommends a complete release of the sixth dorsal compartment. Long-standing controversy exists regarding the need for retinacular repair to prevent subluxation (2, 3), but four references (2, 4, 5, 6) cite no cases of post-operative subluxation.

Regarding the requested service of endoscopic vs open right cubital tunnel release, ODG Treatment has specific guidelines regarding surgery for this condition. Therefore, according to Texas Labor Code Sec. 137.100 (9): "Treatments and services provided within the ODG are presumed to be reasonable and reasonably required; therefore, preauthorization is not required for treatments provided within the ODG, except in certain circumstances. Since adoption of the ODG, preauthorization is required when... 3) the treatment or service is under study or not recommended in the ODG..."

ODG Treatment guidelines regarding surgery for cubital tunnel syndrome do not indicate that the treatments are "under study", however there is no mention of endoscopic cubital tunnel release.

All of the following conservative treatments are required prior to surgery (8):

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.

The recommendations for exercise are generic recommendations given for all elbow conditions in ODG Treatment, and are specifically relevant only for lateral and medial epicondylitis and are contraindicated in cubital tunnel syndrome. The anatomic cubital tunnel is a space deep to the flexor carpi ulnaris muscle just distal to the medial epicondyle. The ulnar nerve travels in the cubital tunnel where it is covered by a rigid transparent membrane which compresses the ulnar nerve. Strengthening exercises to the wrist flexors would hypertrophy the flexor carpi ulnaris, thus increasing the pressure on the nerve (the opposite of the desired effect).

In the letter of 04/15/09, the Attending Physician states: "All lower levels of care have been exhausted, specifically activity modification, splinting and injections...only provided temporary significant relief and her symptoms have recurred." Careful review of the prior sections of this letter and other medical records submitted show that activity modifications, splinting and injections were attempted at the right wrist, not the right elbow. There is no documentation of night splinting to prevent elbow flexion, daytime splinting to avoid direct pressure on the ulnar nerve or NSAID prescriptions. All of the above must be attempted (or documented as contraindicated) prior to consideration for surgery according to ODG criteria.

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

DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

<http://www.tdi.state.tx.us/wc/rules/adopted/documents/aorderprme1207.pdf>

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines Treatment, online version. Work Loss Data Institute, Encinitas, CA

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[Green's Operative Hand Surgery Online](#), Elsevier, 2009.

Dickson DD, Luckey CA: Tenosynovitis of the extensor carpi ulnaris tendon sheath. J Bone Joint Surg [Am] 30:903-907, 1948.

Hajj AA, Wood MB: Stenosing tenosynovitis of the extensor carpi ulnaris. J Hand Surg [Am] 11:519-520, 1986.

Burman M: Stenosing tendovaginitis of the dorsal and volar compartments of the wrist. Arch Surg 65:752-762, 1952.



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Garsten P: Stenosis of the extensor carpi ulnaris tendon sheath. Acta Chir Scand 101:85-90, 1951.

Nachinolcar UG: Stenosing tenovaginitis of extensor carpi ulnaris: Brief report. J Bone Joint Surg Br 70:842, 1988.

[Wrist arthroscopy: current concepts.](#) Slutsky DJ, Nagle DJ. J Hand Surg Am. 2008 Sep;33(7):1228-44. PMID: 18762125