



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 4-20-10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right cubital tunnel release with ulnar nerve transposition

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

American Osteopathic Academy of Orthopedics

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- MD., office visits on 4-24-08, 9-18-08, 11-20-08, 11-3-09 and 12-29-09.
- EMG/NCS dated 7-14-09 performed by, MD.
- EMG/NCS date 8-28-09 performed by, MD.
- 1-25-10, , MD., performed a Utilization Review.
- 2-19-10, MD., performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

Follow up with Dr. on 4-24-08 notes the claimant complains of neck and shoulder pain. The claimant was not sure regarding the mechanism of injury. The pain began 4 years ago, which is constant. The pain radiates into bilateral deltoid, trapezius, triceps, lateral upper arm, medial forearm, thumb, index finger, ring finger and pinky with symptoms increasing. The claimant rated her pain as 6/10 with 65% in the neck and 35% in the arms. The claimant believes that her injury occurred as part of her normal duties at work, which includes setting up new office equipment, moving computer, furniture, two hour conference calls holding the phone receiver between her head and shoulder while typing. On exam, she is able to walk on heels and toes without difficulty. Cervical ROM shows 20 degrees flexion with pain, 10 degrees extension with pain, 30 degrees of left tilt with pain, 40 degrees of right tilt with pain. Inspection of the cervical region is unremarkable. There are no signs of external injury. Palpation reveals paraspinal tenderness bilateral, trapezius tenderness bilateral and moderate tenderness, moderate bilateral paraspinal spasm. Axial compression tests are normal. Distraction test is normal. Spurlings test i.e., extension and tilting is negative on the left and on the right. Left biceps reflex and left brachioradialis reflex is 1/4. Right biceps reflex, left triceps reflex, right triceps reflex and right brachioradialis reflex is 2/4, Babinski reflex is absent bilaterally. Hoffman reflex is absent bilateral. Graphesthesia on the right hand and left hand extremity are intact. Muscle strength is 5/5 for all groups tested, except as follows: left triceps, deltoid, left wrist flexors, left thumb abductors and left thumb the muscle strength is 4/5. Atrophy is present to the entire left interosseous. The left arm C8 dermatome, C6 dermatome and C1 dermatome demonstrates decreased light touch sensation. Left radial pulse and right radial pulse is normal 2/2. The evaluator recommended an EMG/NCS of bilateral upper extremities, flexion/extension x-rays. The evaluator also requested the MRI films for review.

Follow up with Dr. on 9-18-08 notes the claimant is seen for postop visit. She is status post two months ACDF. She complains of left posterior trapezius pain/atrophy. She was having left deltoid pain that increased since the last visit. She is having some left elbow pain. If her elbow is flexed at a 90 degree angle, she begins to have numbness in the forearm and hand. The claimant's medications include Flexeril, Norco, Lunesta, Maxide, Synthroid and Estotest. On exam, the claimant had tenderness to palpation at trapezius. Neurologic exam of the upper extremities is normal. The claimant has positive Tinel's at the left and right elbow. The evaluator recommended water therapy and begin more aggressive scar massaging. She was given a prescription for bilateral elbow splint.

Follow up with Dr. on 11-20-08, the claimant complains of bilateral neck and arm pain. The cervical pain radiates into the left triceps. The pain is rated as 5/10. She also states increased atrophy in the right hand and increased swelling and numbness bilaterally from the elbow down to the fingers. The right side is worse. The claimant also complains of right elbow pain, no injury or trauma. On exam, the claimant had positive Tinel's sign at the right elbow. The evaluator provided the claimant with an injection to the right ulnar nerve with Lidocaine and Decadron. The claimant was given a prescription for Celebrex 200 mg and progress from water therapy to land surgery.

EMG/NCS dated 7-14-09 performed by, MD., showed findings mildly suggestive of left C7-C8 radiculopathy and mild left cubital tunnel.

EMG/NCS date 8-28-09 performed by, MD., showed mild right median motor neuropathy, mild right cubital tunnel. These findings are in addition/correction to those noted on 7-14-09 indicating left C7-C8 radiculopathy and mild left cubital tunnel.

Follow up with Dr. on 11-3-09 notes the claimant has neck and arm pain rated as 5/10. She has not had her nerve root injection yet. She is waiting on referral to a different pain management doctor. She would like to discuss having cubital tunnel release while waiting on cervical treatment. The claimant's medications include Estotest, Lunesta, Maxide, Norco 325-10 mg and Synthroid. On exam, the claimant has positive Tinel's at the left and right elbow. There is atrophy of the bilateral interosseous left more than right. The evaluator reported the claimant would like to proceed with cubital tunnel release with ulnar nerve transposition. The evaluator requested the procedure for the right cubital tunnel release. The evaluator reported the claimant has right cubital tunnel syndrome that have been resistant to conservative treatment.

On 12-29-09, the claimant was evaluated by, MD. He noted the claimant complained of neck and arm pain on the right. The claimant reported she was not sure of the mechanism of injury. The cervical pain radiates into the right medial forearm and middle finger. The claimant is rated as 7/10. Surgery denial was discussed with the claimant. The claimant has a consult for injection on 12-30-09. On exam, the claimant has paraspinal tenderness bilaterally, trapezius tenderness bilaterally and muscle spasms. The claimant is status post cervical fusion and ulnar nerve neuropathy/cubital tunnel syndrome bilaterally. The evaluator reported that he would place a call to Dr. Schweitzer to see if he will take over as treating physician.

On 1-25-10, MD., performed a Utilization Review. It was her opinion that the decision stands as previously dictated. Notes supplied fail to reveal any significant improvement with conservative treatment course and injection to the cubital area. Claimant has overlapping symptomatology, cervical radiculopathy. She has had prior cervical fusion as well as CTR. Findings on EMG/NCS are mild. It is unlikely that surgical intervention would be of any significant benefit. The request is not medically necessary.

On 2-19-10, MD., performed a Utilization Review. The evaluator reported that the claimant is a 46 year old female with a date of Injury on 3-5-04. She had a C4-6 fusion. She also had a previous cubital tunnel release. She complains of left arm pain and decreased grip and sensory loss in C7-C8 dermatome. There have been recent requests for cervical nerve root injections C7-C8. There has been an EMG which demonstrates both a cervical radiculopathy and mild cubital tunnel syndrome and mild carpal tunnel syndrome. The claimant has multiple confounding variables including a previous C4-6 fusion, a previous cubital tunnel release (CTR) and an EMG demonstrating cervical radiculopathy. The current request is for cubital tunnel release with ulnar nerve transposition. There are multiple pain generators, only mild cubital tunnel on EMG, and not an adequate documentation of conservative measures

specifically related to the cubital tunnel. In addition, regarding the surgery request, the trend and standard is a less invasive procedure without ulnar nerve transposition. This is supported in the literature which was cited. The request for the surgery is considered not medically necessary as the claimant does not meet ODG criteria and has multiple pain generators. She most likely would have continued pain and complaints after surgery.

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

Records indicate a positive study for cubital tunnel syndrome (although mild) it is still a positive study on two tests; also there is objective positive findings for ulnar nerve compression and reasonable documented failure of conservative care over more than 6 months. Therefore, the request for right cubital tunnel release with ulnar nerve transposition is reasonable and medically indicated.

ODG-TWC, last update 3-26-10 Occupational Disorders of the elbow – cubital tunnel release: 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.

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 KNOWLEDGBASE
- 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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)