Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

CLAIMS EVAL

Utilization Review and Peer Review Services

DATE OF REVIEW: 9-28-10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Neuroplasty and/or transposition ulnar nerve at elbow

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

American Board of Orthopaedic Surgery-Board Certified

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

- 8-11-06 X-rays of the cervical spine.
- 8-11-06 MRI of the left shoulder.
- 8-11-06 Cervical myelogram.
- 8-11-06 CT scan of the cervical spine post myelogram.
- 10-5-06 MD., evaluated the claimant.
- 4-24-07 MD., Designated Doctor Evaluation.
- 5-30-08 X-rays of the left shoulder.
- 5-30-08 MRI of the left shoulder.
- 6-3-09 X-rays of the cervical spine.
- 7-28-09 X-rays of the left elbow.
- 4-14-10 MD., office visit.
- 7-15-10, MD., performed a Utilization Review.
- 8-13-10, MD., performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

8-11-06 X-rays of the cervical spine shows early cervical spondylosis involving C5-C6, C6-C7 disc spaces.

8-11-06 MRI of the left shoulder shows findings consistent with impingement syndrome. There is partial thickness tearing undersurface of the rotator cuff at the junction of posterior supraspinatus with infraspinatus tendons. No full thickness rotator cuff tear is identified. Mild shoulder joint osteoarthritis with diffuse areas of mild degenerative labral fraying and partial thickness degenerative superior labral tear.

8-11-06 Cervical myelogram is normal.

8-11-06 CT scan of the cervical spine post myelogram showed degenerative disc disease is seen involving C5-C6, C6-C7 disc spaces. Minimal posterior osteophyte formation is noted at C5-C6 level with slight impingement on the subarachnoid space but without impingement on the spinal cord. The finding is not appreciated on the cervical myelogram. Disc protrusion seen at C6-C7 level is not appreciated on the cervical myelogram. Remainder of the cervical intervertebral discs appears normal. No evidence of spinal stenosis. Normal spinal cord.

10-5-06, MD., evaluated the claimant. He reported that the claimant injured his neck, back and left shoulder on xx-xx-xx. He had an intervening unrelated cardiac admission on 12-3-04. Cervical and lumbar MRI's revealed degeneration and an L5-S1 herniation/annular tear, as well as a C5-C6 herniated nucleus pulposus to his reading. A cervical myelogram in August 2006 was read as normal. An August 2006 shoulder MRI showed partial tearing. The claimant did not respond to cervical epidural steroid injection and has not returned to work. The evaluator felt that the diagnosis was causally related to the injury. The claimant has degenerative changes in all three areas and has been treated with epidural steroid injections from a prior injury to the neck, from which he reported essentially complete recovery. The evaluator reported that a Functional Capacity Evaluation was not indicated due to his cardiac status. The evaluator reported that the claimant is to see Dr. for his cervical spine and he felt that this consultation is appropriate. As it relates to the shoulder, it was his opinion the claimant should have steroid injections in the subacromial space. The claimant listed he takes Lyrica, Naproxen, Protonix, Metoprolol, Plavix, Hydrocodone 5/500 mg and Hydrocodone 7.5/500 mg, Oxycontin 10 mg, aspirin, Amitriptyline 100 mg, Lipitor, Piroxicam, Methocarbamol, Amitriptyline 50 mg, Ultracet, Promethazine, Ambien and Methadone. In my opinion the examinee does not need to be all these for his orthopedic injuries. He is also on significant cardiovascular medication, but in my opinion the only indicated medications for the compensable injury are Hydrocodone 7.5/500 mg 1 every 8 hours as needed for pain. The Methocarbamol, Ultracet, Piroxicam, Hydrocodone 5/500 mg and Naproxen 500 mg are not reasonable and necessary and related. Obviously, this examinee is on several anti-inflammatory medications as well as aspirins and Plavix and it seems dangerous to me for the examinee to be taking all these medications. On another sheet of paper that he gave, he listed only Bupraban 150 mg, NitroQuick .4 mg, Indomethacin 25 mg, Lipitor 80 mg, Cyclobenzaprine 10 mg and Hydrocodone 10/500 mg. In his opinion this examinee should not be on muscle relaxant medication at this point. It will only complicate his symptoms in his opinion and cause sedation. Therefore, he did not see the indication for Cyclobenzaprine or Indomethacin for his compensable injury. Methadone is the only one of the medications that would require weaning to stop and that should be under the supervision of his pain management physician due to the relative complexity of his clinical picture.
On 4-24-07, MD., performed a Designated Doctor Evaluation. It was his opinion that the claimant's medical condition resulting from the worker's compensation injury has prevented and still prevents the claimant from returning to work. He has difficulty walking after recovering from his heart attack.

5-30-08 X-rays of the left shoulder shows no evidence of fracture or dislocation.

5-30-08 MRI of the left shoulder shows minimal acromioclavicular degenerative disease and bursitis. There are cystic changes and possible old Hill-Sachs deformity at the posterior superior aspect of the humeral head. There is slight irregularity of the anterior inferior labrum suggesting a possible undisplaced labral tear or degenerative changes. Correlation with any prior history of dislocation is recommended. Postoperative changes in the anterior and lateral deltoid so correlation with prior surgical records is recommended from 2007.

6-3-09 X-rays of the cervical spine shows prior fusion at C5-C6. No acute osseous abnormality and no significant change since 1-30-09.

7-28-09 X-rays of the left elbow showed no radiographic evidence for acute osseous injury to the elbow.

On 4-14-10, MD., evaluated the claimant. He noted that the claimant has had a long history of medical problems including neck, back, shoulder, and arm problems. He had an operation on his left shoulder for the second time done by a Dr. in, and he also had an ulnar nerve decompression by him that was done in 2009, and the reason for the consultation from the referring health care provider is because there have been persistent problems with that arm and shoulder. The shoulder operation that was performed, he said there was some relief of pain, especially in the neck region and arm. He has improvement, but the arm pain is very difficult. He has numbness that is persistent to the ring and small fingers and is yet to go away. He said that the ulnar nerve surgery that was done on his left arm made his arm worse than it was before the operation and it has continued to be problematic for him. The previous nerve studies by history, which he did not have a copy for, suggest persistent ulnar nerve problems at the elbow. Exam shows positive Tinel's in the region of the ulnar nerve and it appears it is still in the posterior aspect behind the medial epicondyle radiating to the ring and small fingers with guarding with flexion and extension and generalized pain in the forearm and elbow region, ring and small fingers, as well as decreased sensation at 12 mm. APB, EPL and first dorsal interosseous, there is guarding as compared to the contralateral side. The shoulder has a linear scar present and abduction at 90 degrees, external rotation at 10 degrees and forward flexion to 100 degrees was noted. There is limited internal rotation to L4. The evaluator reported that the shoulder is certainly an issue, but as far as surgical treatment, the left elbow, based on the history is following that the ulnar decompression that was done, the patient was immediately worse following it and is yet to get better as well as the fact that there is persistent nerve studies that consist with pathology at that area of the ulnar nerve, which suggest that the ulnar nerve is still problematic, revision operation would be potentially helpful, but again there is no way to guarantee with this complex problem of neck, shoulder problems, and ulnar nerve operation. Again, there are no guarantees with it, but clinically, there are still signs of irritation localized. The history and the fact that the surgery was perceived by the patient to be worse than it was. The problem was worse postop than preop. He suggested possibly a revision ulnar nerve surgery to be done. That is the only recommendation he had.

On 7-15-10, MD., performed a Utilization Review. The request for revision of left ulnar nerve is not medically necessary at this time. The clinical documentation indicates the patient has undergone a previous ulnar nerve decompression 2009. No prior operative reports were submitted for review. There is also no indication that the patient has undergone any conservative treatment for left elbow symptoms to date. There was also no electrodiagnostic study submitted for review to provide objective findings of left cubital tunnel syndrome.

Official Disability Guidelines recommend simple decompression of the ulnar nerve for patients who have been unresponsive to conservative care. Additional clinical documentation would need to be submitted for review before the appropriateness of this request could be established. As such, medical necessity for the request for revision of the left ulnar nerve has not been established at this time. Conclusion/Decision to Not Certify: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced below, the request for revision of the left ulnar nerve is not medically necessary at this time. As there is a lack of documentation of conservative care, the request for revision of the left ulnar nerve is not medically necessary at this time.

On 8-13-10, , MD., performed a Utilization Review. He noted that this patient sustained an injury on xx/xx/xx after sustaining an injury while unloading kitchen cabinetry. The patient had an x-ray done of the left elbow on 7/28/09 showing no evidence of an acute osseous injury. The most recent note provided for review is dated 4/14/10 documenting previous ulnar nerve decompression in 2009. The patient reported persistent problems with the arm, and shoulder. The patient reported numbness in the ring and small fingers. He had positive Tinel's in the region of the ulnar nerve, and still in the posterior aspect behind the medial epicondyle radiating to the ring, and small fingers with guarding of flexion and extension. He has decreased sensation and pain in the forearm/elbow region, ring, and small fingers. It was his opinion that Medical necessity is not established with application of ODG: elbow chapter: ODG Indications for Surgery - Simple Decompression (SD) for cubital tunnel syndrome The request is going to peer review because it is unclear if the claimant has exhausted lower level conservative care. The request for revision of ulnar nerve left is not medically necessary. There is no documentation of recent electrodiagnostic studies or conservative care. The patient has not been evaluated since 4/10. There was no documentation of conservative care, and no prior operative note. It would be prudent to determine the post-operative condition of the nerve with a nerve study and compare this to the pre-operative study. This was not available for review.
On 9-22-10 at 4:00 pm, my office contacted Dr. office to obtain any further medical records, if available. My staff was transferred to voice mail and left a detailed message.
On 9-23-10 at 11:40 am, my office contacted Dr. office to obtain any further medical records, if available. One of my office staff-members spoke with who informed that Dr. had only seen the claimant once, on 4-14-10, which is included in the records I was provided for review.

On 9-27-10, a call was placed to to obtain a copy of the electrodiagnostic testing done on the claimant. I was informed that the test was approved in August 2009, but there was no documentation that this was ever done.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
MEDICAL RECORDS REFLECT A CLAIMANT WITH A HISTORY OF ULNAR NERVE DECOMPRESSION IN 2009. THE CLAIMANT COMPLAINS OF NUMBNESS THAT IS PERSISTENT AT THE RING AND SMALL FINGERS. THE CLAIMANT REPORTED THAT POST SURGERY, HIS ARM WAS WORSE THAN PRIOR TO SURGERY. THE CLAIMANT SAW DR. WHO REPORTED THE CLAIMANT'S ULNAR NERVE REMAINS PROBLEMATIC AND A REVISION OPERATION WOULD BE POTENTIALLY HELPFUL. THERE ARE NO REPEATED ELECTRODIAGNOSTIC TESTING SHOWING PATHOLOGY AT THE ULNAR NERVE. THEREFORE, THE REQUEST FOR NEUROPLASTY AND/OR

TRANSPOSITION OF THE ULNAR NERVE AT THE ELBOW IS NOT REASONABLE OR MEDICALLY INDICATED AT THIS JUNCTURE.

ODG-TWC, last update 4-28-10 Occupational Disorders of the Elbow – Surgery for 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 isotonically 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 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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**