

CASEREVIEW

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Notice of Independent Review Decision

DATE OF REVIEW: November 17, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Detachment and Reattachment, distal biceps tendon, right elbow; posterior interosseous nerve decompression right elbow.

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

This physician is Board Certified by American Board of Orthopedic Surgeons with over 40 years of experience.

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant is a who first noticed symptoms around xx/xx/xx after pulling the start cord

of a chainsaw. The power tool would not start and he pulled the cord several times before he had to stop because of excruciating pain around the anterior lateral aspect of this right elbow. He sought care a month later.

On March 21, 2011, the claimant was initially evaluated by MD for persistent pain in his right elbow, particularly with resisted supination. On physical examination there was full range of motion of the elbow in flexion/extension as well as pronation/supination, however, the last few degrees of extension were painful. There was well localized maximal tenderness over the radial nerve and supinator muscle. There was moderate tenderness along the radial nerve in the proximal third of the forearm along the common extensor tendon and supinator. Resisted forearm supination produced increasing tenderness at the anterolateral aspect of the elbow. There was increased pain with gripping with elbow extension versus elbow flexion. There was no tenderness along the radiocapitellar joint and insertion of the LCL into the proximal lateral ulna. Impression: Radial tunnel syndrome, right elbow and right elbow pain. Plan: The claimant has a probable supinator muscle strain with evidence of radial tunnel syndrome. Dr. recommended conservative treatment with stretching exercises and avoidance of activities which exacerbate pain.

On May 2, 2011, the claimant had a follow-up evaluation with MD who on physical examination found negative Tinel's over the cubital tunnel. Maximum point of tenderness was over the mobile wad just anterior to the elbow joint over the course of the radial nerve. X-rays of the right elbow showed no evidence of arthritis and the humeral ulnar joint appeared to be concentrically reduced. No evidence of loose bodies within the olecranon or coronoid fossa. Dr. recommended a MRI of the right elbow and possibly an EMG/NCV.

On June 7, 2011, MRI of the right elbow revealed: 1. Mild tendinosis of the distal biceps insertion without tear. There is evidence of bicipital radial bursitis as well as mild interosseous bursitis between the proximal radius and ulna. 2. The adjacent radial neurovascular bundle including the division into the superficial radial nerve branch and

the posterior interosseous nerve branch appears normal both proximal to and within the supinator muscle. 3. Mild tendinosis at the common extensor tendon origin at the lateral epicondyle without evidence of lateral epicondylitis or tear.

On June 17, 2011, the claimant had a follow-up evaluation with MD who found on exam some mild tenderness along the most distal aspect of the biceps tendon. There appeared to be increasing tenderness with supination of the forearm and eccentric elbow flexion. There was no tenderness over the lateral epicondyles. There was no point tenderness over the radial nerve. Plan: The claimant most likely has bicipital tendinitis and Dr. would recommend nonsteroidal anti-inflammatory medications. If no improvement over next 3 months would consider detachment and reinsertion of the distal biceps tendon.

On August 19, 2011, the claimant had a follow-up evaluation with MD who noted his symptoms persisted despite being on anti-inflammatory medications. On exam there was tenderness to palpation over the radial nerve underneath the mobile wad. There was also tenderness along the course of the distal biceps tendon down to its insertion into the radial tuberosity. There was full range of motion of the elbow. Dr. recommended and EMG/NCV.

On August 30, 2011, EMG/NCV revealed: This is an abnormal nerve conduction and EMG study of upper extremities. The findings are multiple. Right posterior interosseous neuropathy is present, moderate in extent, without any fibrillation potentials of muscles. Mild electrical median neuropathy is present bilaterally. Mild left ulnar neuropathy at the elbow is suspected. There is no evidence of cervical radiculopathy or myopathy present.

On September 26, 2011, the claimant had a follow-up evaluation with MD for persistent anterior and lateral elbow pain. Dr. diagnosed him with probable radial tunnel syndrome based on his symptomatology and also a partial distal biceps tendon rupture based on the results of the MRI. The recent nerve conduction study demonstrated and supported a right posterior interosseous neuropathy. Dr. reported he failed a course of anti-inflammatory medications. On examination there was tenderness to palpation directly over the course of the posterior interosseous nerve. There was also mild tenderness with supination of the forearm particularly over the distal biceps tendon which is enlarged as it goes to its insertion into the radial tuberosity. There is increasing pain with resisted elbow flexion and supination. Dr. recommended proceeding with treatment for a partial distal biceps tendon rupture and radial tunnel syndrome. He recommended performing both a detachment and reattachment of the partial distal biceps tendon tear as well as decompression of the posterior interosseous nerve at the level of the elbow and supinator muscle.

On October 5, 2011, MD performed a UR on the claimant. Rationale for Denial: In the extremely short note furnished by the requesting provider, he stated that he feels that the claimant has "radial tunnel syndrome" based on the symptoms. The following is the Official Disability Guidelines/Treatment in Workers' Compensation (evidence-based

protocols) criteria for surgery of such a diagnosis: Recommended as an option in simple cases after 3-6 months of conservative care plus positive electrodiagnostic studies and objective evidence of loss of function. Surgical decompression of radial tunnel syndrome (RTS), a relatively rare condition, remains controversial because the results are unpredictable. Surgical decompression may be beneficial for simple RTS, but may be less successful if there are coexisting additional nerve compression syndromes or lateral epicondylitis or if the patient is receiving worker's compensation.

On October 11, 2011, MD performed a UR on the claimant. Rationale for Denial: Provider's notes reflect that the patient has not had PT or conservative care for this injury as read to me by provider's representative. The following is the Official Disability Guidelines/Treatment in Workers' Compensation (evidence-based protocols) criteria for surgery of such a diagnosis: Recommended as an option in simple cases after 3-6 months of conservative care plus positive electrodiagnostic studies and objective evidence of loss of function. Surgical decompression of radial tunnel syndrome (RTS), a relatively rare condition, remains controversial because the results are unpredictable. Surgical decompression may be beneficial for simple RTS, but may be less successful if there are coexisting additional nerve compression syndromes or lateral epicondylitis or if the patient is receiving worker's compensation.

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

The previous decisions have been upheld. The request for detachment and reattachment, distal biceps tendon, right elbow has been denied because according to the medial records he has symptoms of pain in his lateral elbow and the MRI of the right elbow did not indicate a ruptured biceps tendon. The requested surgery would not relieve elbow pain. The request for posterior interosseous nerve decompression right elbow was also denied because the claimant has signs/symptoms of muscle and/or tendon pain with history of muscle/tendon injury. There was no muscle weakness recorded and the EMG showed multiple nerve involvement, therefore, according to the ODG the procedure would not be recommended.

ODG:

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| Surgery for radial tunnel syndrome (lesion of radial nerve) | Recommended as an option in simple cases after 3-6 months of conservative care plus positive electrodiagnostic studies and objective evidence of loss of function. Surgical decompression of radial tunnel syndrome (RTS), a relatively rare condition, remains controversial because the results are unpredictable. Surgical decompression may be beneficial for simple RTS, but may be less successful if there are coexisting additional nerve compression syndromes or lateral epicondylitis or if the patient is receiving workers' compensation. (Lee, 2007) |
| Surgery for ruptured biceps tendon (at the elbow) | Recommended as indicated below. Surgery may be an appropriate treatment option for tears in the distal biceps tendons (biceps tendon tear at the elbow) for patients who need normal arm strength. Nonsurgical treatment is usually all that is needed for tears in the proximal biceps tendons (biceps tendon tear at the shoulder). (Mazzocca, 2008) (Chillemi, 2007) (Rantanen, 1999) <u>ODG Indications for Surgery</u> -- Ruptured biceps tendon surgery: Criteria for reinsertion of ruptured biceps tendon with diagnosis of distal rupture of the biceps tendon: All should be repaired within 2 to 3 weeks of injury or diagnosis. A |

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| | diagnosis is made when the physician cannot palpate the insertion of the tendon at the patient's antecubital fossa. Surgery is not indicated if 3 or more months have elapsed. (Washington, 2002) |
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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)