

AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

[Date notice sent to all parties]: November 29, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right ulnar nerve submuscular transfer

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

This physician is Board Certified Orthopedic Surgeon with over 40 years of experience.

REVIEW OUTCOME:

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

Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

02-24-10: Office visit at

03-18-10: Progress Note

03-26-10: MRI Right Elbow at Diagnostic MRI

03-30-10: Progress Note

04-12-10: New Patient Consultation

04-26-10: Follow up visit

05-24-10: Notes at

07-19-10: Follow up visit

07-22-10: Office Visit

09-01-10: Nerve Conduction Study

09-16-10: Office Visit

09-23-10: Request for Right ulnar nerve subcutaneous anterior transfer

09-28-10: Operative Report

10-13-10: Office Visit

11-10-10: Office Visit
06-25-12: Office Visit
08-10-12: Electromyogram and Nerve Conduction Studies Report
08-31-12: Office Visit
09-07-12: UR
10-12-12: UR
11-05-12: Office Visit

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a right hand dominant female that was injured while working. She was sorting and distributing mail in top slots when she hit her elbow on a lower slot.

Claimant complains of pain in the posterior elbow with radiation down the ulnar aspect of the forearm and hand, with numbness and tingling in an ulnar nerve distribution. Pain is described as a dull burning pain and moderate in intensity and is exacerbated by use of the elbow and hand and not alleviated by anything. Claimant has had bilateral carpal tunnel releases one year prior to date. Right Elbow: ROM is normal but with pain. Pain reported during hand gripping in the affected hand. Tingling reported along ulnar aspect of forearm and hand. Assessment: 1. Elbow contusion. 923.11. Plan: Claimant has some features of an ulnar nerve contusion. Ice packs 15 minutes at a time, no longer than 15 minutes, protecting skin from direct contact with the ice and waiting at least 45 minutes between applications. Two gel packs were provided. Physical therapy three times per week for one to two weeks. Evaluate and treat. Modified activity: limited use of right hand. F/U Monday.

3-18-10: Progress Note. Claimant has been working within the duty restrictions. Claimant noted some relief with medications and slight improvement with physical therapy, feeling slight improvement in her functional status. She reported that during PT, ultrasound exacerbated her pain greatly. She feels that something is loose in the elbow. Physical Exam: Right Elbow: ROM is painful. Pain noted with hand gripping. Moderate tenderness noted with palpation over the olecranon. Assessment: 1. Elbow Contusion. 932.11. Plan: MRI to look for possible occult fracture as X-rays is negative. Continue modified activity and physical therapy without ultrasound. F/U Tuesday.

03-26-10: MRI Right Elbow. Impression: 1. Mild medial epicondylitis. 2. Nonspecific increased signal in the ulnar nerve, without enlargement.

03-30-10: Progress Note. Claimant continues to work with duty restrictions and has been taking medication with some relief of symptoms. She continues to have pain in the medial elbow with radiation down the forearm and complains of ongoing tenderness with mild occasional numbness and weakness. PE: Musculoskeletal: Right Elbow: ROM painful with pain to resisted supination and resisted pronation. There is marked tenderness to palpation over the medial epicondyle and olecranon. Assessment: 1. Elbow contusion. 923.11. 2. Medial epicondylitis. 726.31. Plan: Refer to orthopedic surgeon for failure of

conservative management. Modified activity: limited use of right hand/arm. Continue Aspirin and Ultram ER and ice packs. Hold PT until she sees the orthopedic surgeon.

04-12-10: New Patient Consultation. Chief complaint is right elbow pain. Currently claimant is taking Tramadol and had 8 PT visits. She states feeling as this is helping some, but still having 7/10 pain in the right medial elbow. Physical Examination: Right elbow has marked tenderness with ROM at the posterior part of the medial epicondyle and the biceps tendon. She has positive resisted wrist extension and pronation tests; doing both of these movements together cause quite a bit of pain at the medial epicondyle. Positive Tinel's at the cubital tunnel. She has negative normal static two-point discrimination in all fingers except for the ulnar side of the small finger which is 7 mm. Assessment: 1. Right medial epicondylitis. 2. Right cubital tunnel syndrome. Plan: Claimant requested an injection and does not want surgery at this time. An injection is the next step to see if we can resolve the medial epicondylitis. There may be need for ulnar nerve transposition if ulnar nerve symptoms do not improve. Requested nerve study prior to previous surgical procedures, if unavailable may need to repeat.

04-26-10: Follow up visit. Claimant stated that she does not want surgery however complains of numbness in her small and ring finger every time she flexes her elbow, especially at nighttime in which is waking her up almost every night now. Continues with pain in the medial epicondylar areas. Strongly positive Tinel sign at the medial part of the elbow right over the ulnar nerve cubital tunnel noted. Injection given in the medial epicondylar area. Elbow splint prescribed to keep the elbow in 30 degrees of flexion at nighttime for therapy. Follow up in 4 weeks to consider cubital tunnel release if there is no improvement from injection and splint.

05-24-10: Note. Claimant stated that the injection resolved most of the pain at first and reduced numbness in the medial forearm and small finger. She is still having intermittent numbness, but stated feeling like it is improving. Right elbow has slight tenderness just proximal to the medial epicondyle. Slightly positive Tinel's with firm tapping. Claimant is improving and should continue light work and doing nothing to aggravate the problem. Avoid elbow flexion at nighttime if possible. Follow up in 4 weeks to consider release.

07-19-10: Follow up visit. Claimant is still having pain in the elbow at the medial epicondylar area and numbness and tingling in the small finger mostly, to some degree constant. Her pain radiates down the medial forearm. Exam shows positive Tinel's at ulnar elbow with positive tenderness at the medial epicondyle and pain with resisted wrist flexion and pronation directly at the medial epicondylitis. Claimant stated she is not improving and had similar pain in the left elbow and required surgery for improvement. Claimant needs medial epicondylar release combined with ulnar nerve transposition. Prescribed Ultram.

07-22-10: Office Visit. Claimant describes her right elbow pain as sharp and severe that worsens with activities. Her pain level is worst at 7/10 and symptoms worse when bumping, twisting, gripping and light lifting. Claimant complains of

numbness and upper extremity pain numbness that radiates to the hand. Right elbow exam: Tenderness to medial epicondyle, flexor-pronator. Ulnar: Positive Tinel's ulnar elbow and Phalen's ulnar elbow. Impression: Right medial epicondylitis of elbow (726.31), R/O Cubital tunnel syndrome (354.2), R/O Carpal tunnel syndrome (354.0). Plan: Explained to claimant to try nonoperative treatment, leaving surgery as a last resort. Activity: modify so as to avoid anything that causes pain. DME applied: claimant has elbow nighttime extension splint that doesn't help much, and she does get some night relief from carpal tunnel splint. EMG to r/o cubital tunnel, which is obvious on exam/history. Follow-up: after EMG. Plan for ulnar nerve transposition, recommended depending on nerve study.

09-01-10: Nerve Conduction Study. Impression: 1. Bilateral ulnar nerve compressions at the level of the elbow (cubital tunnel syndrome), right greater than left. Ulnar nerve lesions were indicated by reduced ulnar motor conduction velocity values recorded across the below elbow to above elbow segments bilaterally, reduced ulnar motor amplitude values recorded from the right elbow stimulation site relative to the wrist stimulation site, and increased reinnervation potential activity recorded within ulnar innervated musculature bilaterally. 2. Mild to moderate bilateral carpal tunnel syndrome, which is primarily demyelinating in nature. Carpal tunnel syndrome was indicated by prolonged median sensory distal latency value recorded at the first and second digits bilaterally. 3. No electrophysiological evidence of cervical radiculopathy and/or brachial plexopathy was recorded in these electrodiagnostic studies of the upper extremities.

09-23-10: Request for Right ulnar nerve subcutaneous anterior transfer. Rationale: provider documents positive ulnar nerve compression at the elbow via upper extremity electrodiagnostic study, as well as per physical examination. Conservative management has not allowed for a symptom free state. Reasonable surgical request. (Important-this claimant has pre-existing bilateral upper extremity compressive neuropathy as evidence by prior surgical intervention to the opposite side). Determination: certify.

09-28-10: Operative Report. Postoperative Diagnosis: Right cubital tunnel syndrome. Procedure: Right subcutaneous anterior transfer of the ulnar nerve.

10-13-10: Office Visit. Claimant stated she is doing fine after nerve release surgery and her fingers are feeling better, and her pain is controlled with medication. She reported her current pain level as 2/10. She is having numbness in the 4th and 5th digit due to splint on hand and complains of itching on the skin. Impression: Recovering very well after ulnar nerve transposition. F/U in 4 weeks.

11-10-10: Office Visit. Claimant stated her pain is better yet a 4/10, but controlled with medication. No neuro complaints. She is requesting PT as she does not have full extension/flexion of the right elbow. Impression: Status post: Right ulnar nerve subcutaneous anterior transfer. Plan: recovered well, release. Return to activity as tolerated.

06-25-12: Office Visit. Claimant presented with complaints of right arm numbness and pain. She stated noting her right arm burning pain, mostly around medial aspect of elbow and radiates around elbow for the past 2-3 months. No acute re-injury or trauma noted. Claimant noted right elbow numbness, mostly around surgical scar that worsens when she uses a computer for extended periods. She noted hypersensitivity around olecranon of elbow. Symptoms reported to have started approximately 3 months ago. Physical examination: Right Elbow: AROM: Extension: 0; Flexion: 120. Impression: Status post: Right ulnar nerve subcutaneous anterior transfer. Claimant had temporary relief after surgery, but now has symptoms returning (recurring) cubital tunnel, and MABC neuroma. She also describes minor lateral epicondylitis. Plan: EMG to evaluate and possible submuscular revision surgery needed. Continue current medications: Vicodin ES 7.5-750mg tabs PO Q4-6 hrs PRN pain and new medication Lyrica 75mg PO BID. F/U after EMG.

08-10-12: Electromyogram and Nerve Conduction Studies Report. Interpretation: 1. There is evidence of right ulnar neuropathy affecting the right ulnar sensory nerve, and to a lesser extent right motor nerve through the cubital tunnel. No abnormalities are noted in the left ulnar nerve study. 2. There is evidence of bilateral median neuropathy at the wrists, consistent with a clinical diagnosis of carpal tunnel syndrome bilaterally of moderate severity, slightly worse on the right side than the left, without evidence of associated acute denervation.

08-31-12: Office Visit. Claimant stated her symptoms are unchanged. She was given a Medrol Pak which helped her symptoms but has worn off. She describes her pain as sharp and severe 8/10 pain. Right Elbow Examination: Tenderness: Tender distal to the scar, slightly, but no area that I can find has a + Tinel's. Neurovascular Exam: Ulnar: provocative tests/signs positive: Tinel's ulnar elbow, Phalen's ulnar elbow, FDP IV/V weakness. Impression: Right recurrent cubital tunnel syndrome, s/p right ulnar nerve subcutaneous anterior transfer. Claimant has had temporary relief after surgery, but now has symptoms returning (recurring) cubital tunnel, MABC neuroma could be part of the problem. Plan: Right ulnar nerve submuscular transfer. Because of the poor success with non-surgical treatments and the persistence of the problem, it is felt that non-operative treatment has been maximized, and thus the claimant requests surgery and it is indicated. Non-operative treatments attempted, which have had temporary effect, or no effect, in improving the patient's condition: activity modification, therapy, splinting, injection. New medication: Neurontin 300mg PO TID.

09-07-12: UR. Reason for denial: Treatment guidelines would not support proceeding with an ulnar nerve decompression unless lower levels of care consisting of splinting and anti inflammatory medications had first been initiated. The current documentation does not support that the claimant has undergone padding, splinting or recent physical therapy or use of anti inflammatory medications with the reoccurrence of symptoms. Additionally, the treating provider is requesting a repeated transposition of the ulnar nerve; this was previously accomplished with the initial surgical intervention. Ulnar nerve transposition are only indicated if the ulnar nerve subluxes with range of motion of

the elbow which is not documented in the physical examination findings; therefore, the request cannot be certified at this time. There are no objective physical examination findings of any subluxation of the ulnar nerve with range of motion of the elbow to support the medical necessity of a transposition of the nerve as opposed to a simple decompression. A simple decompression cannot be certified at this time due to lack of lower levels of care being exhausted at this point. The request for right ulnar nerve submuscular transfer is not certified.

10-12-12: UR. Reason for denial: The reconsideration for right ulnar nerve submuscular transfer is not certified. The previous reviewers' non certification on 9/7/12 by is supported. There are no additional medical records available for review. There is no documentation of post operative lower levels of care of padding or splinting of the elbow for a three month trial period, use of anti inflammatory medications, physical therapy or activity modifications. Surgical transfer of the ulnar nerve is not recommended unless the ulnar nerve subluxes on range of motion of the elbow. There is no documentation of subluxation of the ulnar nerve. Based on the medical records available for review, the previous reviewers' non certification and the peer reviewed evidence based official disability guidelines the request for reconsideration of right ulnar nerve submuscular transfer if not medically supported and not certified.

11-05-12: Office Visit. Claimant presented with right elbow pain located at the lateral and medial elbow. She describes her pain as sharp and severe. Pain is noted to worse when reaching overhead, reaching behind her back, lying on the shoulder, twisting, gripping, writing, light lifting. Associated symptoms: swelling, stiffness, upper extremity pain. Right Elbow Exam: no deformity, swelling, ecchymoses or atrophy. Impression: Right recurrent cubital tunnel syndrome: nothing clinical has changed. Plan: Unsure why the denial for services are denied as submuscular is frequently used as a revision procedure when in situ or subcutaneous or intramuscular are not effective or if symptoms recur after those. Follow up once IRO is completed.

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

After carefully review of the records including the operative report and follow up visits, it would be my opinion that she has developed a recurrent of the ulnar nerve impingement at her right elbow. She has had conservative care including steroids, extension braces, and job modification without significant relief. She has EMG evidence of cubital tunnel syndrome of the right elbow. I would recommend right ulnar nerve submuscular transfer at the elbow as recommended. I would recommend that the previous denials be overturned. Please see ODG for indications for surgery. Therefore, after reviewing the medical records and documentation provided, the request for Right ulnar nerve submuscular transfer is considered medically necessary and approved.

Per ODG:

Surgery for cubital tunnel syndrome (ulnar nerve	<u>ODG Indications for Surgery</u> -- Surgery for cubital tunnel syndrome: Initial conservative treatment, requiring ALL of the following: - <u>Exercise:</u> Strengthening the elbow flexors/extensors isometrically and isotonicly
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entrapment)	<p>within 0-45 degrees</p> <ul style="list-style-type: none"> - <u>Activity modification</u>: 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. - <u>Medications</u>: Nonsteroidal anti-inflammatory drugs (NSAIDs) in an attempt to decrease inflammation around the nerve. - <u>Pad/splint</u>: 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.
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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)