

# CASEREVIEW

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## Notice of Independent Review Decision

**DATE OF REVIEW:** May 19, 2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Urgent Left Ulnar Nerve Transposition 64718

**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)

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:**

09/12/11: Initial Evaluation by  
09/12/11: Left Ribs X-ray, 2 views, interpreted by  
09/12/11: Cervical Spine X-ray, 2 views, interpreted by  
09/12/11: Left Shoulder X-ray, 2 views, interpreted by  
09/16/11: Follow-up Evaluation by  
09/16/11: Chest X-ray, single view, interpreted by  
09/22/11: Initial Physical Therapy Evaluation by  
09/23/11: MRI Left Shoulder interpreted by  
10/03/11: EMG/NCS performed by  
10/04/11: Follow-up Evaluation by  
10/04/11: Consultation Evaluation by

10/10/11: Evaluation by  
10/18/11: Operative Report by  
10/19/11: Office Visit by  
10/24/11: Physical Therapy Discharge Summary by  
10/24/11: Plan of Care by  
11/15/11: Progress Note by  
11/21/11: Office Visit by  
11/23/11: Progress Note by  
12/19/11: Office Visit by  
12/21/11: Progress Note by  
01/20/12: Office Visit by  
01/20/12: Progress Note by  
02/27/12: Office Visit by  
03/06/12: EMG/NCV Study of the left upper extremity interpreted by  
03/07/12: Office Visit by  
03/09/12: UR performed by  
03/13/12: Progress Note by  
03/22/12: UR performed by  
04/04/12: Office Visit by  
05/07/12: Letter from

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who was injured on xx/xx/xx. The claimant reportedly injured the left side of neck, back, shoulder, side, arm, hand and fingers.

On September 12, 2011, the claimant was evaluated at for complaints in his left arm. His pain was rated 7/10. He had pain to the left side of his neck, left lateral chest, left shoulder, and numbness to the left 4<sup>th</sup> and 5<sup>th</sup> fingers. On physical examination he had tenderness of the left lateral neck muscles. He was unable to raise left arm because of pain in his left chest and left shoulder area. Chest wall left lateral ribs were tender to palpation. He had numbness in the left ring and little fingers and the claimant reported weakness of the other three fingers. X-rays of the left shoulder, left ribs, and C-spine were negative. Diagnosis: 1. Cervicalgia. 2. Shoulder strain. 3. Sprain of ribs. 4. Paresthasias fingers. Plan: Continue previous medication as prescribed and he was referred for therapy 3 times per week for 1 to 2 weeks.

On September 16, 2011, the claimant was re-evaluated by ordered a MRI of the left shoulder and an EMG/NCV of the left upper extremity. X-rays of the chest revealed findings suggestive of left upper lobe lingular subsegmental atelectasis/scarring, mild granulomatous disease of the chest, and findings suggestive of emphysema. He was prescribed Ultram 50 mg and recommended to continue with previous therapy schedule.

On September 23, 2011, MRI Left Shoulder, Impression: 1. Left shoulder distal supraspinatus tendon tear which appears full thickness with a small amount of fluid in

the subacromial/subdeltoid bursa. 2. AC joint arthritis. 3. Mild degenerative spurring from the inferior glenoid but no joint narrowing.

On October 3, 2011, EMG/NCS of the left upper extremity, Assessment: Electrophysiologic studies were performed and confirmed what appeared to be an ulnar nerve entrapment neuropathy at the elbow. It did seem to involve the motor and sensory portion of the nerve and seemed to be mild. Coupled with his rotator cuff injury, it would explain his inability to move his arm. There is no evidence of radiculopathy. IMPRESSION of the EMG/NCS: Mild slowing of the ulnar sensory and motor nerve across the elbow, suggestive of an ulnar neuropathy at the ulnar groove. No evidence of radiculopathy.

On October 4, 2011, the claimant was re-evaluated by for ongoing pain to the left shoulder and numbness to fingers of the left hand. His pain was rated a 9/10. Diagnosis: 1. Complete rupture of rotator cuff. 2. Spain of ribs. 3. Ulnar neuropathy. Plan: Referred to ortho for elbow injection and rotator cuff. He was also referred to his pulmonary doctor for surgical clearance.

On October 4, 2011, the claimant was evaluated by the claimant's pulmonary doctor. opined that from a pulmonary standpoint he was doing well and was suitable for GETA should he wish to have surgery.

On October 10, 2011, the claimant was evaluated by for evaluation of his left shoulder. His pain was described as sharp and severe and disabling. His pain was continuous, worse with activity and rated a 5/10. Treatments tried to date were ice, muscle relaxants, physical therapy and TENS unit. Physical examination was limited to the left shoulder. Diagnosis: Left shoulder rotator cuff tear. Plan: Left shoulder arthroscopy with subacromial decompression and mini rotator cuff repair.

On October 18, 2011, Operative Report by for a left shoulder arthroscopy with subacromial decompression and left mini-open rotator cuff repair.

On October 24, 2011, the claimant was evaluated at for physical therapy to the left shoulder.

On December 21, 2011, physical therapy progress notes from did indicate that the claimant had numbness in the ulnar nerve distribution persisting with symptoms (numbness and weakness) manifested in the 4<sup>th</sup> and 5<sup>th</sup> digits. This was repeated in the January 20, 2012 progress note.

On February 27, 2012, the claimant was evaluated by who reported his symptoms had remained unchanged since his last visit and his current pain level was a 0. He did have complaints of pain with overhead activity and night pain. On physical exam of his left shoulder he was neurovascularly intact. There were no signs or symptoms of infection, incisions were well healed. Active ROM was normal except for internal rotation which was measured at 75 degrees. Muscle strength was 5/5. Diagnosis: Status post left

shoulder arthroscopy with subacromial decompression and mini open rotator cuff repair.  
Plan: Referred to for further evaluation on left arm neuropathy.

On March 6, 2012, EMG/NCV study of the left upper extremity, Impression: The study reveals evidence of a severe left cubital tunnel syndrome (ulnar nerve entrapment near or at the elbow) affecting the sensory component of the nerves. Also, left Carpal Tunnel Syndrome sensory only. All of patient's sensory nerves were difficult to find and need further correlation with peripheral neuropathy. However, on initial questioning no Sx of peripheral neuropathy present.

On March 7, 2012, the claimant was re-evaluated by who reported his symptoms had worsened. He continued to have numbness and tingling and noted that the medication prescribed did not help. Medications listed were: Aspirin 81 mg, Avodart .5mg, Cyclobenzaprine HCL 10 mg, Synthroid 100 mcg, Advil 200 g, Lamictal 200 mg, Lorazepam 1 mg, Restoril 30 mg, Budeprion XL 150 mg, Nexium 40 mg, Vicodin 5-500 mg, and Norco 10-325 mg. On physical examination of his left elbow there was no pain/tenderness, crepitus, instability, deformity, swelling or mass. Active ROM was normal. Muscle strength was 5/5. He did have numbness/tingling in ulnar nerve distribution and positive tinels at the elbow. Diagnosis: Left ulnar nerve neuropathy and left cubital tunnel syndrome. Plan: An ulnar nerve transposition was recommended.

On March 9, 2012, performed a UR on the claimant. Rationale for Denial: There is no evidence of subluxation of ulnar nerve; no evidence of a trial of padding and night extension splint; no evidence of trial of PT.

On March 13, 2012, a physical therapy progress noted that the claimant had not attended therapy since 02/17/12 secondary to other medical issues. The pt states he will have surgery on ulnar nerve early next month. He will be placed on hold for the surgery to be completed.

On March 22, 2012, performed a UR on the claimant. Rationale for Denial: Conservative care has included medications. ODG criteria for ulnar decompression at the elbow include clinical ulnar neuropathy, significant activity limitations, delayed NCV, and failure of conservative treatment. In addition, ODG states that surgical transposition of the ulnar nerve is not recommended unless the ulnar nerve subluxes on ROM of the elbow. However, the specific extent, modalities, and duration of conservative care rendered to date beyond medication was not delineated. In addition, there is no evidence of ulnar nerve subluxation with elbow motion. It is unclear why an ulnar nerve transposition is required as opposed to a simple decompression. Therefore the request is non-certified.

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

The previous adverse determinations are upheld. ODG states “Transposition may only be required if the ulnar nerve subluxes on ROM of the elbow. Otherwise simple decompression is recommended.” There was no documentation in the medical records provided reporting that there is subluxation of the ulnar nerve during ROM of the elbow. Furthermore, ODG indicates that the following conservative measure should be completed prior to cubital tunnel surgery: Exercise, Activity modification, Medications, and Pad/splint. The majority of the medical records received were regarding the claimant’s left shoulder problems. There was documentation of complaints of numbness and weakness in the left hand 4<sup>th</sup> and 5<sup>th</sup> fingers in the early medical records from September and October of 2011. Two EMG/NCS studies also documented ulnar entrapment at the elbow. However, there was no documentation of exercise or physical therapy for the left elbow (all therapy notes were for the diagnosis of left rotator cuff tear and therapy was centered on the left shoulder). There was also no documentation of activity modification by a physician (did state in his letter that he had modified his activity) or Medication prescribed by a physician to help decrease inflammation around the nerve. There were also no medical records where a physician ordered a trial of an elbow pad or night splinting. Therefore, ODG criteria of conservative treatment prior to cubital tunnel surgery does not appear to have been met.

The claimant does have documentation of left ulnar entrapment (cubital tunnel syndrome) of the left elbow by EMG/NCS which may very well need to be surgically treated with a simple decompression. However, the medical records severely lacked in documentation of physical examination and treatment regarding the left elbow and ulnar neuropathy. Therefore, the request for Urgent Left Ulnar Nerve Transposition 64718 is denied.

**PER ODG GUIDELINES:**

<p>Surgery for cubital tunnel syndrome (ulnar nerve entrapment)</p>	<p>Recommended as indicated below (simple decompression in most cases). Surgical transposition of the ulnar nerve is not recommended unless the ulnar nerve subluxes on ROM of the elbow. Surgery for ulnar neuropathy at the elbow is effective at least 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 generally advised. (<a href="#">Bartels, 2005</a>) (<a href="#">Asamoto, 2005</a>) (<a href="#">Lund, 2006</a>) (<a href="#">Nabhan, 2007</a>) 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. (<a href="#">Bartels2, 2005</a>) (<a href="#">Nabhan, 2005</a>) 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. (<a href="#">Nathan, 2005</a>) Medial epicondylectomy for persons with cubital tunnel syndrome was superior to anterior transposition in relieving pain and in</p>
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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. ([AHRO, 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](#))

*Simple decompression vs anterior transposition:* Transposition may only be required if the ulnar nerve subluxes on ROM of the elbow. Otherwise simple decompression is recommended. ([Heithoff, 1999](#)) ([Posner, 1998](#)) ([Bartels, 2005](#)) ([Elhassan, 2007](#)) Irrespective of the surgical method, roughly 90% of patients are satisfied with surgical treatment of the ulnar nerve entrapment. However, one specific group of patients (people with habitual ulnar luxation or subluxation of the ulnar nerve) experienced a distinctly better result when treated by anterior transposition than by simple decompression, so simple decompression of the ulnar nerve can be recommended in all patients without cubital (sub)luxation of the nerve, whereas people with a tendency of cubital (sub)luxation of the ulnar nerve should be treated by submuscular anterior transposition. ([Bimmler, 1996](#)) In this study, both simple decompression and anterior transposition resulted in improvement in over 80% of cases, but a higher percentage of full recovery was seen in the cases treated by simple decompression. ([Chan, 1980](#)) The results of simple decompression of the ulnar nerve are similar to transposition, so the former simpler method is recommended as the standard procedure. ([Lugnegård, 1982](#)) The advantages of simple decompression make it the procedure of choice for most cases of ulnar neuropathy. ([Nathan, 1992](#)) The simpler procedure of neurolysis in situ is the treatment of choice, but submuscular transposition remains appropriate in certain circumstances. ([Biggs, 2006](#))

**ODG Indications for Surgery -- Surgery 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 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)**