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Notice of Independent Review Decision

DATE OF REVIEW: 05/10/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient right cubital tunnel release and right endoscopic carpal tunnel release (CTR)

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

Board Certified Orthopaedic Surgeon

REVIEW OUTCOME:

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

<input type="checkbox"/>	Upheld	(Agree)
<input checked="" type="checkbox"/>	Overtured	(Disagree)
<input type="checkbox"/>	Partially Overtured	(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:

1. 09/09/10 – Radiographs Cervical Spine
2. 09/09/10 – Radiographs Lumbar Spine
3. 09/09/10 – Radiographs Bilateral Elbows
4. 09/09/10 – Radiographs Bilateral Hips
5. 11/02/10 – Clinical Note –MD

6. 11/11/10 – Clinical Note –MD
7. 11/16/10 – MRI Cervical Spine
8. 11/16/10 – MRI Right Shoulder
9. 11/23/10 – Clinical Note –MD
10. 12/09/10 – Clinical Note –MD
11. 12/21/10 – Clinical Note –MD
12. 01/06/11 – Clinical Note –MD
13. 01/20/11 – Clinical Note –MD
14. 01/25/11 – Clinical Note –MD
15. 02/08/11 – Clinical Note –MD
16. 02/10/11 – Clinical Note –MD
17. 02/17/11 – Operative Report
18. 02/24/11 – Clinical Note –MD
19. 03/08/11 – Clinical Note –MD
20. 03/10/11 – Clinical Note –MD
21. 03/24/11 – Clinical Note –MD
22. 04/08/11 – Clinical Note –MD
23. 04/19/11 – Medical Record Review –MD
24. 05/03/11 – Post-Myelogram CT Cervical Spine
25. 05/16/11 – Clinical Note –MD
26. 06/01/11 – Correspondence –MD
27. 06/14/11 – Laboratory Report
28. 07/07/11 – EMG Re-Read –, MD
29. 08/08/11 – History & Physical
30. 08/10/11 – Operative Report
31. 08/10/11 – Neurophysiological Monitoring Report

32. 08/10/11 – Radiographs Cervical Spine
33. 08/13/11 – Clinical Note – Unspecified Provider
34. 08/25/11 – Clinical Note –MD
35. 10/24/11 – Clinical Note –MD
36. 11/11/11 – Clinical Note –MD
37. 11/22/11 – Operative Report
38. 11/23/11 – Clinical Note –, MD
39. 11/29/11 – Clinical Note – MD
40. 01/18/12 – Clinical Note –MD
41. 02/02/12 – Electrodiagnostic Studies
42. 02/13/12 – Clinical Note –MD
43. 03/01/12 – Clinical Note –MD
44. 03/06/12 – Clinical Note –MD
45. 03/13/12 – Notice of Utilization Review Findings
46. 03/16/12 – Clinical Note –MD
47. 03/16/12 – Correspondence –MD
48. 03/27/12 – Notice of Utilization Review Findings
49. 04/04/12 – Clinical Note –MD
50. 04/23/12 – Physical Therapy Plan of Care

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee sustained an injury on XX/XX/XX when she fell on the right side of her body at floor level. Radiographs of the cervical spine performed 09/09/10 revealed no acute fracture or dislocation. There was degenerative change, bony spondylosis, and disc space narrowing at C5-6 and C6-7. There was bony thickening/spur formation at C6-7. Radiographs of the bilateral elbows performed xx/xx/xx were unremarkable. Radiographs of the lumbar spine performed xx/xx/xx revealed degenerative changes and disc space narrowing at L4-5. Radiographs of the bilateral hips performed 09/09/10 were unremarkable.

The injured employee saw Dr. on 11/02/10 with complaints of pain to the cervical spine and right shoulder. Physical exam revealed tenderness to palpation of the cervical musculature bilaterally and into the right medial scapular border. Range of motion was restricted with pain. There was tenderness with right shoulder abduction beyond 90 degrees. Radiographs of the right shoulder revealed diminished acromiohumeral space. There was no presence of recent fracture or dislocation. The claimant was given a steroid injection to the right cervical paravertebral musculature.

MRI of the cervical spine performed 11/16/10 revealed moderate to severe spondylosis with disc protrusions/extrusions causing spinal stenosis from 3 through C7. There was ligamentum flavum hypertrophy and congenitally small spinal canal. There was uncovertebral and facet hypertrophy with neural foraminal narrowing. There was kyphosis of the cervical spine with anterior disc height loss. MRI of the right shoulder performed 11/16/10 revealed acromion anomaly and spurring associated with impingement. There was a small free margin tear of the superior glenoid labrum. There was fiber fraying/tear of the superior aspect of the subscapularis tendon.

The injured employee was given a right shoulder steroid injection on 11/23/10 and 12/09/10. She also underwent right C5-6 cervical epidural steroid injection on 02/17/11. Electrodiagnostic studies performed 03/10/11 revealed right C6-7 radiculopathy, as well as bilateral upper extremity peripheral neuropathy. There was no evidence of focal nerve entrapment.

The injured employee saw Dr. on 03/24/11 with complaints of pain to the neck and right shoulder with associated tingling of the hand and fingers. Physical exam revealed tightness and discomfort of the neck with tightness of the upper extremities. There was decreased strength of the right upper extremity. The reflexes were 3+. The claimant was recommended for surgical intervention of the shoulder prior to addressing the neck. Post-myelogram CT of the cervical spine performed 05/03/11 revealed mild stenosis of the canal at C2-3. At C3-4, there was endplate spur formation without a focal disc abnormality. There was mild right foraminal narrowing with moderate to marked left-sided stenosis. At C4-5, there was a 3mm central disc protrusion that impinged on the cord. There was mild bilateral foraminal narrowing. At C5-6, there was endplate spur formation and associated disc protrusion. There was cord impingement and canal stenosis. There was mild bilateral foraminal narrowing noted. At C6-7, there was endplate spur formation and possible calcified disc herniation with compression of the cord and cord atrophy. There was marked bilateral foraminal narrowing noted. At C7-T1, there was endplate spur formation without a focal disc abnormality. There was mild left foraminal narrowing seen without right-sided stenosis.

An EMG re-read by Dr. on 07/07/11 revealed mild, acute right C6 radiculopathy. An acute, active axonal pathology at the right brachial plexus could not be ruled out. There was mild median sensorimotor mononeuropathy at the bilateral wrists, consistent with carpal tunnel syndrome. There was evidence of ulnar

mononeuropathy. There was evidence of mild, underlying generalized diabetic peripheral neuropathy.

The injured employee underwent C5, C6, C7, T1 laminectomy with facetectomy and foraminotomy, C4-5, C5-6, C6-7, and C7-T1 posterior cervical fusion with segmental instrumentation from C4 to T1 on 08/10/11.

The injured employee saw Dr. on 08/25/11 with complaints of neck pain with shooting arm symptoms. Physical exam revealed a benign-appearing posterior midline approach scar to the cervical spine without erythema, fluctuance, or discharge. Impingement sign was positive on the right with weakness of the right rotator cuff. Radiographs of the cervical spine revealed a well-positioned C4 to T1 posterior cervical fusion. Multilevel posterior decompression was noted. He was recommended for a home exercise program and fitted for an external bone growth stimulator.

The injured employee saw Dr. on 11/11/11 with complaints of right shoulder pain rating 8 out of 10. Physical exam revealed weakness of the supraspinatus, infraspinatus, and subscapularis. Range of motion testing revealed elevation to 70 degrees and external rotation to 50 degrees. There was tenderness to palpation of the acromioclavicular joint and greater tuberosity. She was recommended for surgical intervention.

The injured employee underwent arthroscopic right shoulder subacromial decompression, acromioplasty, and distal clavicle resection on 11/22/11.

The injured employee saw Dr. on 11/29/11 with complaints of neck pain with shooting arm symptoms. Physical exam revealed a benign-appearing midline posterior cervical incision without erythema, fluctuance, or discharge. There was diffuse pain to palpation of the posterior cervical paraspinal musculature. Cervical range of motion was limited. Spurling's was positive. There was sensory deficit in the right hand in the ulnar distribution. Tinel's was moderately to severely positive at the right cubital and carpal tunnels. There was full strength throughout. Radiographs of the cervical spine revealed a posterior cervical decompression and instrumented fusion from C4 to T1 without obvious loosening of the hardware.

The injured employee was recommended for physical therapy of the neck. She saw Dr. on 01/18/12 with complaints of numbness of the right elbow with radiation down to the fingers. She reported improved range of motion with physical therapy. Physical exam revealed a well-healed scar to the right shoulder. Range of motion testing revealed elevation to 155 degrees and external rotation to 25 degrees. There was weakness of the supraspinatus, infraspinatus, and subscapularis. There was diffuse tenderness to palpation on the right side. Atrophy sign was normal. The injured employee was recommended for electrodiagnostic studies. Electrodiagnostic studies performed 02/02/12 revealed moderately severe right proximal ulnar neuropathy. There was evidence of mild

to moderate right median neuropathy at the right, consistent with right carpal tunnel syndrome. There was no evidence of an acute right C5-T1 radiculopathy.

The injured employee saw Dr. on 03/01/12 with complaints of neck pain with shooting arm symptoms. Physical exam revealed a benign-appearing midline posterior cervical incision without erythema, fluctuance, or discharge. There was diffuse pain to palpation of the posterior cervical paraspinous musculature. Cervical range of motion was limited. Spurling's was negative. There was sensory deficit of the right arm. Tinel's was positive at the cubital and carpal tunnels bilaterally. There was give-way weakness of the right upper extremity. Radiographs of the cervical spine revealed stable appearance from C4 to T1. There was early lucency formation about the right T1 screw.

The injured employee was recommended for physical therapy.

The injured employee saw Dr. on 03/06/12 with complaints of diffuse numbness of the fingers diffusely. There was some numbness of the feet. Physical exam revealed positive Tinel's along the median nerve from just below the axilla, across the elbow, and into the hand. Tinel's was positive at the ulnar nerve. Phalen's was negative. She was assessed with bilateral hand symptoms with non-localizing neurologic exam and probable peripheral neuropathy of unclear etiology. The note states there was no causal relationship between a possible carpal and cubital tunnel, and there was no demonstrable evidence of discrete carpal or cubital tunnel separate from the peripheral neuropathy. As such, surgical intervention was not recommended.

The request for outpatient right cubital tunnel release and right endoscopic carpal tunnel release (CTR) was denied by utilization review on 03/13/12 as it was not clear that she had exhausted conservative care measures for either the cubital or carpal tunnel.

The injured employee saw Dr. on 03/16/12 with complaints of right shoulder pain rating 9 out of 10. Physical exam revealed a well-healed scar. Range of motion testing revealed elevation to 90 degrees and external rotation to 25 degrees. There was weakness of the supraspinatus and infraspinatus. There was diffuse tenderness to palpation of the right side. Compression tests were positive on the right. Percussion tests were positive on the right. She was assessed with right carpal tunnel syndrome and right elbow cubital tunnel syndrome. The injured employee was recommended for right cubital tunnel release and right endoscopic carpal tunnel release.

An appeal letter by Dr. dated 03/16/12 states conservative management for an injury that was 1.5 years old and one of severity of dense nerve function was not an indication for a conservative approach. The injured employee was diabetic and the exam was not focal. The note states that based on the mechanism of injury and the initial complaints, surgical intervention was recommended.

The request for outpatient right cubital tunnel release and right endoscopic carpal tunnel release (CTR) was denied by utilization review on 03/27/12 due to lack of physical examination findings and appropriate conservative treatment.

The injured employee saw Dr. on 04/04/12 with complaints of right shoulder pain rating 8 out of 10. Physical exam revealed positive compression tests on the right. Atrophy signs were positive. Percussion tests were positive on the right. She was assessed with right carpal tunnel syndrome and right elbow cubital tunnel syndrome. The injured employee was recommended for right cubital tunnel release and right endoscopic carpal tunnel release. A physical therapy evaluation dated 04/23/12 recommended the claimant for 12 sessions of physical therapy to address poor posture, limited cervical range of motion, decreased right upper extremity strength, and high subjective pain ratings. The injured employee reported difficulty with activities of daily living and lack of compliance with home exercise program.

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

Based on the clinical documentation provided for review, the requested right cubital and carpal tunnel release is recommended as medically necessary based on **Official Disability Guidelines**. The physical exam findings and EMG/NCV studies provide sufficient objective evidence to support a diagnosis of both right cubital and carpal tunnel syndrome. The injured employee has undergone conservative care and given the duration of symptoms and objective evidence of atrophy, additional conservative measures are not needed. As such, medical necessity for the requested procedures is established.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

REFERENCES:

Official Disability Guidelines, Elbow Chapter, Online Edition

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.

Official Disability Guidelines, Carpal Tunnel Chapter, Online Edition
ODG Indications for Surgery™ -- Carpal Tunnel Release:

I. Severe CTS, requiring ALL of the following:

A. Symptoms/findings of severe CTS, requiring ALL of the following:

1. Muscle atrophy, severe weakness of thenar muscles
2. 2-point discrimination test > 6 mm

B. Positive electrodiagnostic testing

--- OR ---

II. Not severe CTS, requiring ALL of the following:

A. Symptoms (pain/numbness/paresthesia/impaired dexterity), requiring TWO of the following:

1. Abnormal Katz hand diagram scores
2. Nocturnal symptoms
3. Flick sign (shaking hand)

B. Findings by physical exam, requiring TWO of the following:

1. Compression test
2. Semmes-Weinstein monofilament test
3. Phalen sign
4. Tinel's sign
5. Decreased 2-point discrimination
6. Mild thenar weakness (thumb abduction)

C. Comorbidities: no current pregnancy

D. Initial conservative treatment, requiring THREE of the following:

1. Activity modification \geq 1 month
2. Night wrist splint \geq 1 month
3. Nonprescription analgesia (i.e., acetaminophen)
4. Home exercise training (provided by physician, healthcare provider or therapist)

5. Successful initial outcome from corticosteroid injection trial (optional).

See Injections. [Initial relief of symptoms can assist in confirmation of diagnosis and can be a good indicator for success of surgery if electrodiagnostic testing is not readily available.]

E. Positive electrodiagnostic testing [note that successful outcomes from injection trial or conservative treatment may affect test results] (Hagebeuk, 2004)