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Notice of Independent Review Decision

December 2, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right elbow ulnar nerve subcutaneous transposition

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

Orthopedic Physician

REVIEW OUTCOME:

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained injury on xx/xx/xx, when he fell. He sustained injuries to the right elbow and developed numbness, tingling and pain shooting into all of his fingers since that time.

On November 14, 2013, the patient was evaluated for right elbow pain since xx/xxxx. He was a known case of hypertension. The diagnoses were sprain of elbow, radial neck fracture, injury of median nerve and contusion of ulnar nerve. Ongoing medications were Valium and Norco. The patient smoked more than one pack of cigarettes per day. (The office visit note is incomplete.)

On November 20, 2013, evaluated the patient after being referred for the right elbow injury. The patient was treated conservatively for tears of the collateral ligaments seen on magnetic resonance imaging (MRI). He was attending

physical therapy (PT). He complained of paresthesia shooting down into the fingers on both sides of arm. Examination of the right upper extremity revealed some tenderness over the ulnar nerve. Range of motion (ROM) was 10-120 degrees of full pronation/supination without pain. Tinel's, elbow flexion and compression were positive reproducing symptoms at the elbow and positive Tinel's compression and Phalen's that produced symptoms. reviewed x-rays from October that revealed healed and aligned radial head fractures. Electrodiagnostic studies had shown both median and ulnar nerve injury with a median and ulnar nerve posttraumatic neuritis. diagnosed right upper extremity posttraumatic median and ulnar neuritis.

On December 16, 2013, performed right open carpal tunnel release (CTR) and ulnar nerve decompression at the elbow.

On January 23, 2014, noted the patient was doing well and making improvement. He had attended four sessions of PT. Examination showed well-healed surgical scars, good ROM of the elbow and wrist, and decreased edema from 20 cm at the wrist to 19.7 cm. Elbow edema had decreased from 36 cm to 34.5 cm. There was improvement in wrist extension, radial and ulnar deviation with therapy, but it was still not normal. recommended another six sessions of therapy and light duty.

On March 6, 2014, the patient reported some catching and some pain in the finger. On examination, noted full ROM of the wrist and lacking about 10 degrees of the elbow but no pain. There was tenderness over the middle finger A1 pulley with catching of the finger. recommended additional PT and instructed him on home strengthening exercises. The patient felt he could not do his regular job yet for a few more weeks. Restrictions were therefore continued for about six more weeks. performed trigger finger steroid injection.

On April 4, 2014, reported the patient was doing pretty well following the surgery, but apparently re-injured himself in the past month or so and developed some increased elbow pain. He reported more pain in the region of posterolateral aspect of the elbow. On examination, he was lacking about 10 degrees of full extension. Flexion, pronation and supination were full. Elbow was ligamentously stable to varus and valgus stress at 0 and 30 degrees. There was continued triggering of the little finger and tenderness over the A1 pulley. A steroid injection administered about six weeks ago did not give any relief of trigger finger. administered steroid injection to the right elbow on the posterolateral aspect and ordered MRI of the elbow. Valium was prescribed.

On May 13, 2014, noted the right elbow steroid injection gave about 50% improvement in elbow pain. The patient still complained of pain on the lateral aspect of the elbow as well as pain along the middle finger with triggering of the middle finger. The patient had reinjured his elbow a few weeks ago when he had fallen and developed pain along the medial aspect of the elbow. On examination, there was tenderness over the distal aspect of the scar, ulnar nerve and on the medial aspect of the elbow with Tinel's producing numbness and tingling into the small finger. There was tenderness over the lateral epicondyle and pain with

resisted extension. ROM was 10 to 130 degrees with full pronation and supination. There was tenderness over the middle finger A1 pulley with triggering of the finger. MRI showed a complete tear of the lateral collateral ligament as well as some thickening and inflammation along the distal aspect of the ulnar nerve. diagnosed right elbow recurrent lateral collateral ligament tear, cubital tunnel syndrome and middle finger triggering and recommended surgery to include revision ulnar nerve decompression to a subcutaneous transposition to free it up more to repair lateral collateral ligament and to release A1 pulley of the middle finger.

On July 17, 2014, noted the recommended surgery was denied twice. The patient continued to have triggering of his middle finger and some tenderness over the lateral epicondyle region with numbness and tingling into the small finger. Tinel's and compression was positive reproducing numbness and tingling down the ulnar aspect of the arm. administered another steroid injection to the volar aspect of the hand and recommended more therapy for strengthening.

On August 26, 2014, evaluated the patient to complete a DARS Work Restriction Report form and for the right elbow injury with nerve damage and residual trigger finger. Right upper extremity strength was decreased to 4/5 in elbow flexion and extension, wrist extension, resisted forearm supination and pronation due to increased pain at the right lateral elbow. There was point tenderness at the right lateral elbow, exacerbated with resisted wrist extension. Rapid alternating movements were mildly slowed in the right hand due to pain. Jamar dynamometer grip strength on the right was 88 and on the left was 100 lbs. Right elbow ROM was mildly restricted with extension to 10 degrees, full extension to flexion normal at 135 degrees, supination to 70 and pronation to 50 degrees. diagnosed residual right lateral elbow epicondylitis and trigger finger status post right elbow fracture and status post repair of elbow fracture and CTS release and ulnar nerve decompression elbow surgeries; morbid obesity and hypertension. He did not give any medical clearance for employment because the patient was not released from his Worker's Compensation situation to pursue active employment with the use of right upper extremity and was planning to return to the surgeon to schedule another RUE surgery. stated although the claimant might engage in academic forms of training or education for future employment, it was presently medically inappropriate for him to do hands-on welding training for the same reason.

On September 4, 2014, reported the patient was seen by a designated doctor, who deferred assessment of maximum medical improvement (MMI) until December and recommended surgery for carpal tunnel release and ulnar transposition. Steroid injection given at the last visit gave about 100% relief of triggering until about a week ago and then the patient started having some residual triggering and some pain. He still complained of numbness and tingling into the index, middle, ring, and small finger with essentially normal motion, but just pain on the lateral aspect of the elbow. On examination, there was tenderness over the lateral aspect of the elbow over the common extensor tendon region, full ROM, and positive Tinel's and pressure over the ulnar nerve at the

elbow as well as positive carpal tunnel provocative test to include Tinel, Phalen and compression. There was persistent tenderness over the middle finger A1 pulley. diagnosed recurrent cubital tunnel syndrome and carpal tunnel syndrome; lateral collateral ligament tear and triggering of the right middle finger; and recommended in view of no improvement with conservative treatment. He recommended A1 pulley release of middle finger, carpal tunnel release, ulnar nerve transposition and repair of lateral collateral ligament.

On September 30, 2014, right elbow ulnar nerve subcutaneous transposition was denied with the following rationale: *“The patient is a male who injured his right elbow on xx/xx/xx due to a fall. An EMG/NCV performed on 11/7/13 showed post-traumatic neuritis of right median and ulnar nerves. Initially, he was treated with medications and physical therapy from 6/24/13 to 12/04/13. The patient underwent right carpal tunnel release and ulnar nerve decompression on 12/16/13. He was treated with medications and physical therapy visits from 12/30/13 to 1/30/14 which provided some relief. He also had corticosteroid injections on the right middle trigger finger on 3/6/14 and right elbow on 4/4/14 which provided 50 percent relief. A left elbow MRI dated 04/24/14 showed radial head fracture healing, moderate radiocapitellar osteoarthritis, and complete radial collateral ligament tear. On 7/17/14 follow-up, he complained of right elbow pain. A physical examination on that visit showed positive Tinel's and Compression test. There was tenderness over the lateral collateral ligament. There is triggering in the middle finger. He had a right hand tendon sheath corticosteroid injection with relief. The recent medical record dated 09/04/14 indicates that the patient had complaints of right elbow pain and middle finger triggering. A physical examination revealed tenderness at the lateral aspect of the elbow over the common extensor origin region. There was positive Tinel's test and pressure over the ulnar nerve along with tenderness over the middle finger A1 pulley. The patient was diagnosed with right cubital tunnel syndrome. A request for right elbow ulnar nerve subcutaneous transposition, lateral collateral ligament repair, and trigger finger release has been made. X-rays of the right elbow were unremarkable. While a right elbow ulnar nerve decompression and trigger finger release is considered, the records submitted for review did not contain specific objective findings such as subluxation of the ulnar nerve with elbow range of motion and positive provocative test for elbow instability to warrant the subcutaneous transposition and lateral collateral ligament repair. In consideration of the foregoing issues and the referenced evidence-based practice guidelines, the medical necessity of the requested surgeries has not been established. As such, the request is non-certified.”*

On October 16, 2014, noted some tenderness and triggering. He performed trigger finger corticosteroid injection and recommended follow up on an as needed basis.

On October 23, 2014, an appeal for right elbow ulnar nerve subcutaneous transposition was denied with the following rationale: *“The patient is male who injured his right elbow on xx/xx/xx due to a fall. The patient is diagnosed with right cubital tunnel syndrome. An appeal for right elbow ulnar nerve subcutaneous*

transposition, lateral collateral ligament repair, and trigger finger release has been made. The request was previously denied since there were no specific objective findings such as subluxation of the ulnar nerve with elbow range of motion and positive provocative test for elbow instability to warrant the requested surgery. There is an updated documentation submitted for review including an appeal letter dated 10/09/14. X-rays of the right elbow are unremarkable. EMG/NCV dated 11/7/13 showed posttraumatic neuritis of right median and ulnar nerves. Initially, he was treated with medications and therapy visits from 6/24/13 to 12/04/13. The patient underwent right carpal tunnel release and ulnar nerve decompression on 12/16/13. He was then treated with medications and physical therapy visits from 12/30/13 to 1/30/14 which provided some relief. He also had corticosteroid injections on the right middle trigger finger on 3/6/14 and right elbow on 4/4/14 which provided 50 %relief. Left elbow MRI dated 04/24/14 showed radial head fracture healing, moderate radiocapitellar osteoarthritis, and complete radial collateral ligament tear. On 07/17/14 follow up, he complained of right elbow pain. A physical examination on that visit showed positive Tinel's and Compression test. There was tenderness over the lateral collateral ligament. There is triggering in the middle finger. He had a right hand tendon sheath corticosteroid injection with relief. On 09/04/14 follow up, the patient complained of right elbow pain and middle finger triggering. Physical examination revealed tenderness at the lateral aspect of the elbow over the common extensor origin region. There was positive Tinel's test and pressure over the ulnar nerve. There was tenderness over the middle finger A1 pulley. The appeal letter dated 10/09/14 indicates that the patient continues to experience pain and difficulty using his arm. While a right elbow ulnar nerve decompression and trigger finger release is considered, the records submitted for review did not contain specific objective findings such as subluxation of the ulnar nerve with elbow range of motion and positive provocative test for elbow instability to warrant the right elbow subcutaneous transposition and lateral collateral ligament repair. In agreement with the previous determination, the medical necessity of the request has not been substantiated."

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

It is not clear based on the medical record provided that a right elbow ulnar nerve transposition is medically appropriate or necessary at this time. While this reviewing physician understands the claimant continues to have right elbow and possible ulnar nerve complaints, there is no documentation in any of the medical records of subluxation of the ulnar nerve and there has not been a postoperative EMG performed documenting incomplete improvement and ulnar nerve function following the initial surgery. While guidelines document the use of ulnar nerve transposition in claimant with unstable ulnar nerve, or possibly with recurrent neuropathy following successful ulnar nerve release, neither one of those has been proven in this claimant in light of the fact that there is no documented instability on motion and no new EMG documenting incomplete improvement or worsening of his ulnar nerve condition. Therefore, there was not enough

information provided on which to say that the surgery would be appropriate and therefore it is not medically necessary.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines (19th annual edition) & ODG Treatment in Workers' Comp (12th annual edition), 2014: Chapter: Elbow (updated 10/20/14)

Transposition of ulnar nerve/Surgery for cubital tunnel syndrome (ulnar nerve entrapment)

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.**