

May 14, 2004

MDR Tracking #:

M2-04-1244-01

IRO #:

5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to \_\_\_ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Orthopaedic Surgery. The reviewer is on the TWCC Approved Doctor List (ADL). The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to \_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

#### CLINICAL HISTORY

This is a request for a medial epicondylectomy and ulnar nerve decompression in this patient whose date of injury is \_\_\_. The initial request was for endoscopic carpal tunnel release, left elbow epicondylectomy and ulnar nerve decompression. The opinion was rendered in the preauthorization process, stating that the patient had mild carpal tunnel syndrome. The ulnar nerve slowing was an incidental finding bilateral. The extent of conservative care in the form of injection, medication and splint have not been documented and therefore the indication for surgery was not confirmed. The patient underwent surgery on 3/5/04 where endoscopic carpal tunnel release was performed. Nerve testing from 12/29/03 revealed very minimal carpal tunnel syndrome and incidental slowing of the ulnar nerve bilateral elbows. The medical records for perusal are hand written notes only, suggesting anti-inflammatories and splinting had been used. Clinic note dated 12/8/03 reports that the patient is a 30 year old with symptoms of numbness, tingling and pain in the left hand and forearm since 8/03. Occupational hazard is typing all day on her job with discussion that if nerve testing were positive then surgery would be carried out. The second review for surgery suggested that there was no documentation of conservative measures and nerve testing showed ulnar neuropathy was an incidental finding and offered a carpal tunnel release only. Neither of the preauthorization reviews had success of contact with the requesting physician. A hand written note from 3/10/04 stated that the patient was only one week postoperative of the left wrist. On clinic note dated 3/31/04, three weeks later, the hand was ok, the elbow was still a problem, recommended a medial epicondylectomy and ulnar decompression.

## REQUESTED SERVICE

Left elbow medial epicondylectomy and ulnar nerve decompression are requested for this patient.

## DECISION

The reviewer agrees with the prior adverse determination.

## BASIS FOR THE DECISION

The initial presentation regarding this patient appeared to be carpal tunnel syndrome in regard to the numbness and weakness in the hand and median nerve distribution. There are two nerve root tests submitted for perusal: one stated mild carpal tunnel syndrome with incidental ulnar nerve slowing; the other test stated ulnar nerve compression with incidental carpal tunnel syndrome. It is unclear which nerve testing was intended for publication, however there is very little discussion regarding conservative care other than anti-inflammatories and splinting. A formal course of physical therapy, differential injections were not carried out; modified activity, etc, was not discussed and the recommendation of elbow surgery was submitted only three weeks post-operative carpal tunnel release. If there is documentation of progressive neurologic deterioration, despite adequate conservative efforts, surgery in itself may ultimately be clinically indicated. Ulnar nerve decompression and risk of residual ulnar nerve changes, despite adequate decompression, has a significantly higher risk than median nerve changes from carpal tunnel surgery. In general principals, the mild slowing at the elbow may or may not be clinically relevant, and without sufficient for convalesce and recovery and rehabilitation for the carpal tunnel release it is in agreement that the necessity for a cascade of surgeries is not confirmed, where there could be spontaneous recovery of the cubital tunnel symptoms with conservative care.

The requestor asked for both surgeries and had a partial approval and carried out the approved carpal tunnel release. The \_\_\_ reviewer finds that further surgery is not indicated for this incidental finding in the perioperative period to where the requested treatment can be successfully managed with non-operative conservative care.

According to Operative Hand Surgery, authored by David Green, Volume 2, Second Edition, reduced velocity less than 25% may not be clinically significant. According to nerve testing submitted for perusal, the slowing across the elbow was only 18%. With no report of atrophy, and with possible insignificant slowing, it is unclear that surgery is mandatory at this time. As this case evolves, indications may change, but according to standard textbooks, there is still time for improvement with conservative care.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of \_\_\_, Inc, dba \_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

### **YOUR RIGHT TO REQUEST A HEARING**

Either party to medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision**, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

**If disputing other prospective medical necessity (preauthorization) decisions**, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk  
P.O. Box 17787  
Austin, Texas 78744  
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 14<sup>th</sup> day of May, 2004.**