

May 2, 2006

TX DEPT OF INS DIV OF WC
AUSTIN, TX 78744-1609

CLAIMANT: ___

EMPLOYEE: ___

POLICY: M2-06-1163-01

CLIENT TRACKING NUMBER: M2-06-1163-01 5278

Medical Review Institute of America (MRIOA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Department of Insurance Division of Workers Compensation has assigned the above mentioned case to MRIOA for independent review in accordance with DWC Rule 133 which provides for medical dispute resolution by an IRO.

MRIOA 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. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the DWC approved doctor list (ADL). The reviewing provider has no known conflicts of interest existing between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

Records Received:

RECORDS RECEIVED FROM THE STATE:

Notification of IRO Assignment dated 4/20/06, 10 pages

RECORDS RECEIVED FROM DR. GAYLON SEAY MD:

Dr. Seay's office records, 3/22/04, 4/5/04, 4/30/04, 5/28/04, 6/25/04, 7/9/04, 7/23/04, 8/30/04, 12/15/04, 1/26/05, 2/11/05, 3/11/05, 3/30/05, 4/13/05, 6/29/05, 7/20/05, 8/2/05, 8/24/05, 9/7/05 - 3/20/06, 29 pages

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RECORDS RECEIVED FROM AMERICAN CASUALTY (RESPONDENT):

Dr. Seay's office records, 3/22/04, 4/5/04, 4/30/04, 5/28/04, 6/25/04, 7/9/04, 7/23/04, 8/30/04, 12/15/04, 1/26/05, 2/11/05, 3/11/05, 3/30/05, 4/13/05, 6/29/05, 7/20/05, 8/2/05, 8/24/05, 9/7/05 - 3/20/06, 29 pages

Concentra UR Appeal Summary and UR Peer Review Summary, 6 pages

Work Status Reports, 6 pages

TWCC-69 Report of Medical Evaluation reports, 2 pages

Lubbock Occupational Health Center - Initial injury Encounter form and Therapy visits 3/8/04-12/7/05, 42 pages

MRI right shoulder report 3/12/04 - negative for cuff tear, but positive AC degenerative changes, 1 page

MRI right wrist report 8/23/05 - suggestion possible L-T tear, 1 page

MRI arthrogram right wrist report 9/1/05 - suggestion thin TFC tear radial aspect, not stated with certainty, 1 page

Convent Surgery center Operative report and anesthesia report 9/27/05 - surgery performed Right wrist excision torn TFC, 2 pages

Highland Medical Center Emergency Room postop shoulder pain 4/28/04, Hospital Record with Operative Note Right shoulder 4/29/04 - excision distal clavicle & acromioplasty

Dr. Hill Impairment Rating Exam, 1/11/05, 7 pages

Dr. Wolcott Nerve conduction study EMG 2/9/05 & 2/16/06, 9 pages

Dr. Ratliff Exam 6/3/05, 8 pages

Duplicate TWCC-69 - Report of Medical Evaluation, 1/14/05, 1 page

Duplicate Work Status Report, 6/25/04, 1 page

Duplicate Lab reports, 3 pages

Duplicate Office notes 4/5/04 and 7/23/04, 2 pages

Summary of Treatment/Case History:

From thorough review of the above records, the patient is a 38 year old male, status post right shoulder and right wrist ligament surgery due to ___ work related injury. The office notes describe a case for right ulnar nerve decompression and transposition. The February 2005 neurodiagnostic test confirms an ulnar nerve conduction velocity across the elbow of 71 ms which is well within normal limits. However, the February 2006 neurodiagnostic test did not measure ulnar nerve conduction velocity across the elbow. The amplitude has decreased, but conduction velocity should be measured prior to recommending/ certifying the operative procedure.

Office records from 3/04 to 3/06 do not discuss perception of numbness, tinels for tunnel of Guyon, elbow flexion test, and interosseus power. Infrequent mentioning of tinels behind the medial epicondyle is noted.

Questions for Review:

1. Please review medical necessity of a right nerve release at the elbow with transposition.

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Explanation of Findings:

1. Please review medical necessity of a right nerve release at the elbow with transposition.

It is recommended that additional neurodiagnostic tests be done confirming an ulnar nerve conduction velocity decrease across the elbow prior to surgical intervention. The patient should be conservatively treated with towel splinting at night and avoidance of pressure to the proximal ulnar 1/3 forearm prior to testing. The present office record does not demonstrate enough diagnostic documentation to recommend the operative procedure at this time.

Conclusion/Decision to Not Certify:

The right ulnar nerve release at elbow with transposition is not medically necessary.

Applicable Clinical or Scientific Criteria or Guidelines Applied in Arriving at Decision:

From Green's Operative Hand Surgery 5th Edition 2005 Chapter 28 Pages 1024-1026

Chronic compression of the ulnar nerve at the cubital tunnel may occur through ischemia or mechanical compression with repeated elbow flexion or direct compression, although the exact etiology may be difficult to identify. The area within the cubital tunnel is decreased with elbow flexion, and this can increase the pressure on the cubital tunnel. Apfelberg and Larson reported a 55% decrease in the cubital tunnel area with elbow flexion. Pechan and Julius reported increased pressure within the cubital tunnel with elbow flexion, and this pressure was further compromised with wrist extension and/or shoulder abduction. Gelberman and colleagues reported with elbow flexion an increased intraneural ulnar nerve pressure and a decreased cubital tunnel volume with elbow flexion. Ulnar nerve subluxation may also contribute to cubital tunnel syndrome. Acute trauma to the ulnar nerve as may occur with distal humeral fractures may compromise ulnar nerve function.

Compression of the ulnar nerve at the cubital tunnel is extremely common and second in incidence only to carpal tunnel syndrome. The diagnosis is a clinical one, because electrodiagnostic testing is often negative. Tinel's sign is usually positive over the nerve at or proximal to the cubital tunnel, but the test is overly sensitive and usually bilaterally positive. While the clinical diagnosis of cubital tunnel syndrome remains the gold standard, electrodiagnostic studies may be used to confirm the diagnosis. The nerve conduction studies and EMGs are useful in localizing the level of nerve compression in addition to identifying other sites of nerve compression or other disease processes (i.e., upper motor neuron disease, peripheral neuropathy) that may be present. To confirm the diagnosis of cubital tunnel syndrome with nerve conduction studies, many reports support the use of a decreased motor conduction velocity across the elbow. Ulnar nerve motor conduction velocity across the elbow of less than 50 m/s is considered positive for cubital tunnel syndrome. Eversmann reported a motor conduction velocity decrease of 33% across the elbow to be indicative of cubital tunnel syndrome. EMG changes in ulnar innervated muscles are more sensitive than nerve conduction studies in the early stages of cubital tunnel syndrome.

Provocative testing for cubital tunnel syndrome using combined elbow flexion with digital pressure placed on the ulnar nerve proximal to the cubital tunnel has good sensitivity and specificity. McGowan described a classification system for ulnar neuropathy at the elbow, and it is based predominantly on

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the loss of ulnar nerve motor function and does not include sensory changes. This classification system is widely quoted in the literature, although it is limited in clinical applicability. In McGowan's classification, grade I neuropathies have no muscle weakness, grade II have muscle weakness with no atrophy, and grade III have muscle atrophy. Clinical evaluation is important to identify patients with cubital tunnel syndrome. Complaints often include paresthesia and numbness in the small and ring finger with aching in the medial elbow and forearm. With severe ulnar nerve compression, patients may present with clawing of the small and ring finger, atrophy of the ulnar nerve-innervated intrinsic muscles, and positive Froment and Wartenberg signs.

These motor changes will not identify the level of ulnar nerve compression. However, many patients present in the early stages of nerve compression and will have no obvious motor deficit. Careful sensory testing as outlined previously can help to quantify changes in sensibility. In the early stages of nerve compression, provocation testing may be the only positive sign, followed by alteration of threshold testing (vibration and Semmes-Weinstein monofilaments). In the later stages, two-point discrimination will become abnormal. Cubital tunnel syndrome can often be managed conservatively, with education of the patient to avoid positions and activities that combine elbow flexion with pressure over the ulnar nerve, such as while driving, speaking on the telephone, or during sleep. Postural modifications may be necessary for several months before symptoms are resolved, and, occasionally, surgery will be necessary to relieve symptoms. Unfortunately, the incidence of poor outcomes after surgical management of cubital tunnel syndrome far exceeds that of carpal tunnel syndrome; and when surgery fails, the consequences for patients can be devastating.

Unlike carpal tunnel syndrome, there are other sinister diagnoses that can mimic cubital tunnel syndrome, such as motor neuron disease or Guillain-Barré syndrome. The surgeon must be alert for the common problem of cervical disk disease and the rare but devastating problem of amyotrophic lateral sclerosis, when evaluating patients with ulnar motor complaints, particularly when the motor findings exceed the sensory findings.

Conservative treatment begins with patient education to avoid postures and positions that increase tension or compression of the ulnar nerve. A demonstration of the changes in skin tension can be useful in explaining the tightness that occurs to the ulnar nerve with elbow flexion. Decreasing elbow flexion and direct pressure on the nerve may help to alleviate symptoms in patients with a mild or moderate degree of nerve compression. Recommendations for nonoperative treatment have included static night splinting of the elbow in extension. Rigid night splints are often ineffective because of patient discomfort and noncompliance. Soft elbow pads can be used to protect the ulnar nerve from direct compression, and we recommend wearing these pads up to 24 hours per day. Because the ulnar nerve can be compressed between the two heads of the flexor carpi ulnaris muscle during hand and wrist activities, patients are instructed in specific stretching and nerve gliding exercises.

In our experience, many patients with mild cubital tunnel syndrome can successfully be managed with 2 to 4 months of nonoperative treatment. Padua and coworkers reported half of their patients with neurophysiologically positive cubital tunnel syndrome improved with nonoperative management. We use motor conduction velocity across the elbow as a guide to management, and treat all patients with conduction velocity of 40 m/sec or greater with a minimum of 2 to 3 months of nonoperative

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treatment. If this is unsuccessful, or if initial conduction is less than 40 m/sec, the patient will likely require surgical intervention. A number of surgical approaches have been described for the treatment of cubital tunnel syndrome and include simple decompression, medial epicondylectomy, and anterior transposition of the ulnar nerve in a subcutaneous, submuscular, intramuscular, or transmuscular position.

References Used in Support of Decision:

Green's Operative Hand Surgery 5th Edition 2005 Chapter 28 pages 1024-1026

The physician providing this review is board certified in Orthopaedic Surgery. The reviewer has added qualification in orthopaedics surgery of the hand. The reviewer is a fellow of the American Academy of Orthopaedic Surgery and the American College of Surgeons. The reviewer is also a member of the American Medical Association. The reviewer has experience in publishing within his specialty and has been in active practice since 1976.

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Chief Clerk of Proceedings / Appeals Clerk

P. O. Box 17787

Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. MRIOA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the DWC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

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The written opinions provided by MRIOA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIOA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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Case Analyst: Stacie S ext 577

cc: Requestor
Respondent