

2011 Procedures Adult Criteria

Ulnar Nerve Decompression, Wrist^(1, 2*RIN, 3)

CLIENT:	Name	D.O.B.	ID#	GROUP#
CPT/ICD9:	Code	Facility	Service Date	
PROVIDER:	Name	ID#	Phone#	
	Signature	Date		

INDICATIONS (choose one and see below)

- ☐ 100 Ulnar neuropathy, wrist
- ☐ Indication Not Listed (Provide clinical justification below)
-
- ☐ 100 Ulnar neuropathy, wrist **[One]**⁽⁴⁾
- ☐ 110 Severe ulnar neuropathy **[Both]**
- ☐ 111 EMG/NCS positive for ulnar nerve compression at the wrist⁽⁵⁾
- ☐ 112 Sx/findings **[One]**
- ☐ -1 Severe weakness of intrinsic hand muscles^(6, 7)
- ☐ -2 Atrophy of intrinsic hand muscles⁽⁷⁾
- ☐ -3 Severe sensory deficit in ulnar nerve distribution^(8, 9, 10)
- ☐ -4 Clawing of ring/small finger⁽¹¹⁾
- ☐ 120 Mild/moderate ulnar neuropathy **[All]**
- ☐ 121 EMG/NCS positive for ulnar nerve compression at the wrist⁽⁵⁾
- ☐ 122 Symptoms in ulnar aspect of hand/wrist/forearm **[One]**⁽¹⁰⁾
- ☐ -1 Pain
- ☐ -2 Paresthesias
- ☐ -3 Numbness
- ☐ -4 Impaired dexterity⁽¹²⁾
- ☐ 123 Findings in ulnar nerve distribution by PE **[One]**^(9, 10)
- ☐ -1 Decreased 2-point discrimination⁽¹³⁾
- ☐ -2 Decreased light touch⁽¹³⁾
- ☐ -3 Weakness of intrinsic hand muscles^(6, 7)
- ☐ 124 Non operative treatment **[One]**
- ☐ -1 Continued Sx/findings **after** Rx **[Both]**⁽¹⁴⁾
- ☐ A) Splint ≥ 6 wks⁽¹⁵⁾
- ☐ B) Activity modification ≥ 6 wks⁽¹⁶⁾
- ☐ -2 Non operative treatment deferred due to weakness and positive EMG findings

Notes

InterQual® criteria are intended solely for use as screening guidelines with respect to the medical appropriateness of healthcare services and not for final clinical or payment determination concerning the type or level of medical care provided, or proposed to be provided, to the patient.

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(1)

These criteria include the following procedure:

Guyon Canal Release

Ulnar Tunnel Release

(2)-RIN:

For ulnar nerve compression at the elbow, see the "Ulnar Nerve Decompression/Transposition, Elbow" criteria subset.

(3)

Decompression of the ulnar nerve consists of surgical exploration of the canal and resection of compressive structures. Ulnar nerve compression at the wrist (ulnar tunnel syndrome) can be caused by repetitive or continuous pressure over the nerve or a variety of space occupying lesions (e.g., ganglion cyst). Three types of involvement have been identified: mixed motor and sensory, pure motor and pure sensory (Erkin et al., Rheumatol Int 2006; 27(2): 191-196; Shapiro and Preston, Med Clin North Am 2003; 87(3): 663-696, viii). Ulnar nerve compression at the elbow is much more common than at the wrist (Erkin et al., Rheumatol Int 2006; 27(2): 191-196).

(4)

The area of compression is at Guyon's canal. Guyon's canal, also known as the ulnar tunnel, is triangular and formed by the superficial transverse carpal ligament (floor), the hook of the hamate (lateral wall), and the pisiform and pisohamate ligament (medial wall).

(5)

EMG or NCS can detect and quantify ulnar nerve sensory and motor conduction latency which, if prolonged, are diagnostic of neuropathy. EMG or NCS are required to localize the site of compression, and can serve to confirm the diagnosis or exclude other diagnoses (e.g., brachial plexopathy or cervical radiculopathy) (Shapiro and Preston, Med Clin North Am 2003; 87(3): 663-696, viii).

(6)

Patients with ulnar neuropathy may experience weakness of the intrinsic hand muscles. One particularly useful test is to have patients grip a piece of paper between their extended thumb and the radial side of their index finger. Inability to hold the paper against resistance without flexing the thumb is a positive Froment's sign and suggests ulnar neuropathy.

(7)

For the purpose of these criteria, the term "intrinsic hand muscles" refers to those muscles of the hand which receive their innervation from the ulnar nerve. These include the interosseous muscles, the lumbrical muscles of the ring and small fingers, and the hypothenar muscles.

(8)

This criterion refers to a profound loss of sensation in the distribution of the ulnar nerve, as determined by sensory testing (e.g., two-point discrimination, light touch, vibration).

(9)

The ulnar nerve sensory distribution is the ulnar side of the hand and forearm (dorsal and palmar surfaces), including the ulnar half of the ring finger and the entire small finger.

(10)

Patients with compression of the ulnar nerve at the wrist have normal sensation on the dorsal medial side of the hand; the superficial sensory branch of the nerve which is often compressed at the elbow is spared compression at the wrist.

(11)

The clawing of ulnar neuropathy refers to a disfiguring claw-like appearance of the ring and small fingers caused by severe weakness of the intrinsic hand muscles.

(12)

Impaired dexterity refers to complaints of hand clumsiness (e.g., dropping small objects or difficulty manipulating them) or weakness (e.g., decreased grip strength). The most common complaints are either difficulty with small buttons or changes in the ability to write if the dominant hand is involved.

(13)

Primary assessments of sensory function include light touch (e.g., monofilament testing), 2-point discrimination, or vibration. Other measures of sensory function (e.g., diminished temperature perception, joint position sense, deep pressure) are useful, but are not

substitutes for vibration, 2-point discrimination, or light touch.

(14)

The listed treatment(s) may have occurred at any time in the course of the illness.

(15)

The goals of splint immobilization in peripheral compression neuropathies are to minimize tension on the injured nerve, to protect it, and to allow resolution of inflammation (Posner, Instr Course Lect 2000; 49: 305-317). Nocturnal symptoms may be relieved by wearing the splint while asleep. Daytime use of the splint should be limited to activities that cause symptoms, to avoid muscle weakness and atrophy from disuse.

(16)

Activity modification for ulnar neuropathy at the wrist involves limiting activities that provoke or aggravate symptoms. These include repetitive wrist hyperextension and hand gripping (e.g., hammering, bicycling, gymnastics), repetitive blunt trauma to the hypothenar eminence (e.g., using the palm in a hammering motion), exposure to excessive vibration (e.g., operating a jackhammer), or acute blunt trauma to the hypothenar eminence. Patients should also be educated about interventions that improve the safety and quality of hand and wrist movement.