



DATE OF REVIEW: 5/3/2007  
IRO CASE #:

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

1. Left ulnar transposition.

**QUALIFICATIONS OF THE REVIEWER:**

This reviewer attended University before graduating from School of Medicine. She did her residency in neurosurgery and a fellowship in pediatric neurosurgery at the Medical Center. She has had numerous publications and is an active member of the Neurological Surgeons and the Neurological Surgeons. She is a licensed medical doctor in five states.

**REVIEW OUTCOME:**

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

- |  |                                  |
|--|----------------------------------|
| Upheld   | (Agree)                          |
| <input checked="" type="checkbox"/> Overturned | (Disagree)                       |
| Partially Overturned                           | (Agree in part/Disagree in part) |

1. Left ulnar transposition. Overturned

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Review organization by, dated 4/16/2007
2. Company request dated 2/14/2007 to 3/23/2007
3. Request form dated 4/5/2007
4. Notice of pre-authorization by MD, dated 2/14/2007
5. Clinical note dated 2/14/2007
6. Follow up evaluation by MD, dated 10/9/2006 to 1/3/2007 multiple dates
7. Radiology report by dated 1/18/2007
8. Radiology report by dated 1/18/2007
9. Medicine consultation by MD, dated 1/19/2007
10. Electrodiagnostic studies dated 1/9/2007
11. Follow up evaluation by MD, dated 2/7/2007
12. Follow up evaluation by MD, dated 3/19/2007
13. Notice of pre-authorization by MD, dated 3/23/2007
14. Worksheet dated 3/23/2007
15. Clinical note dated 3/23/2007
16. Follow up evaluation by MD, dated 1/3/2007 to 3/19/2007
17. Radiology report by dated 1/18/2007
18. Medicine consultation by MD, dated 1/19/2007
19. Electrodiagnostic studies 1/19/2007
20. Follow up evaluation by MD, dated 2/7/2007
21. Review organization note dated 04/16/2007
22. Request for IRO dated 03/23/2007
23. Notice of pre authorization note by MD dated 02/19/2007

Name: Patient\_Name

- 24. Notice of pre authorization note dated 03/28/2007
- 25. Request form dated 04/03/2007
- 26. Case assignment note by dated 04/16/2007

**INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

The injured worker is a male who underwent a two-level anterior cervical discectomy and fusion at C5-6 and C6-7. He is now over 6 months status-post surgery and has continued to have numbness and tingling in his fingers. He has also developed weakness in his hand. A MRI of the shoulder revealed some degenerative joint disease, but no evidence of a rotator cuff tear. A cervical MRI did not show any compromise of the spinal canal above the level of the fusion. An EMG/NCV was noted to show a left ulnar neuropathy at the elbow and chronic EMG changes consistent with a chronic C7 radiculopathy. His provider recommended a left ulnar transposition.

At this time, the request for a left ulnar transposition is under review.

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

The injured worker has evidence of ulnar nerve compression at the elbow and has persistent disabling symptoms which are suggestive of the same. Interpretation of his electrophysiological testing is difficult because he has a superimposed polyneuropathy and chronic cervical radiculopathy. The absence of a Tinnel's sign can be due to his polyneuropathy. It appears, from his cervical MRI, that his cervical issues have been properly addressed surgically. Given failure of conservative therapy, and no other explanation other than ulnar nerve entrapment, this surgery is medically necessary for his condition. Accordingly, the denial is overturned.

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- X MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- X PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

MILLIMAN CARE GUIDELINES

Cubital Tunnel Decompression Procedures (Musculoskeletal Conditions). Cubital Tunnel Syndrome

Padua L, Caliandro P, Aprile I, Sabatelli M, Madia F, Tonali P. Occurrence of nerve entrapment lesion in chronic inflammatory demyelinating polyneuropathy. Clin Neurophysiol. 2005 Sep;116(9):2251-2.

AMR Tracking Num: