

# US Resolutions Inc.

*An Independent Review Organization*

71 Court Street

Belfast, Maine 04915

## Notice of Independent Review Decision

**DATE OF REVIEW: AUGUST 8, 2008**

**IRO CASE #:**

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

Outpatient revision of right ulnar nerve

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

MD, Board Certified Orthopedic Surgeon

### **REVIEW OUTCOME**

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity exists for outpatient revision of right ulnar nerve.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 7/22/08, 7/8/08

ODG Guidelines and Treatment Guidelines

Letter from Law Firm, 7/30/08

MD, 5/19/08, 4/11/08

MRI of Right Elbow, 5/13/08

10/13/00

Patient Status Report, 9/5/00

Employer's First Report of Injury, xx/xx/xx

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This is an injured worker who sustained an injury that resulted in surgery to the right ulnar nerve with a transfer. She apparently did well for many years and recently began to develop recurrence of her symptoms. She underwent an MRI scan, which showed inflammation of the ulnar nerve at the proximal distal end of the previously transplanted nerve. She is now recommended for revision ulnar nerve surgery after failure to improve with conservative treatment.

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

The reviewer finds that medical necessity exists for outpatient revision of right ulnar nerve. Based upon the clinical picture, the MRI scan findings, the ODG Guidelines and the previous history, it is the opinion of this reviewer that the patient does indeed meet criteria for ulnar nerve exploration and decompression. Previous reviewers have questioned the compensability of this particular recurrence. However, based upon the previous injury and previous surgery, this reviewer is of the opinion that the medical necessity for this procedure does exist.

**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
- 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
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)