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One Sansome Street, Suite 600
San Francisco, CA 94104-4448

415.677.2000 Phone
415.677.2195 Fax
www.lumetra.com

Notice of Independent Review Decision

DATE OF REVIEW: 12/21/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left Ulnar Nerve Subcutaneous Anterior Transposition

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

Certified by the American Board of Orthopaedic Surgery

REVIEW OUTCOME

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

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

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	354.2	64718	Overturned
		Prospective	841		Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Physician Notes dated 11/3/08, 10/28/08, 10/15/08, 9/3/08, 8/20/08, 6/11/08, 5/30/08, 5/23/08

X-ray report dated 5/14/08

EMG report dated 10/28/08

Arthrogram dated 8/28/08

Official Disability Guidelines cited but not provided

PATIENT CLINICAL HISTORY:

According to the information provided, this xx-year-old claimant sustained an injury to her arm on xx/xx/xx, when an elevator door closed on her left arm. Left elbow x-ray of xx/xx/xx was negative for acute fracture or dislocation. The treatment plan included Medrol dosepak and physical therapy. Orthopedic consultation of 6/11/08 noted left elbow contusion. The plan included a Heelbo for protection, Naprosyn was prescribed, and the claimant received a steroid injection. Evaluation of 10/15/08 noted problem has become more focal. EMG was obtained on 10/28/08.

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

In the Reviewer's opinion, the requested procedure should be authorized. The Reviewer noted that the claimant continues to have clinical evidence of persistent severe left cubital tunnel syndrome and has failed all conservative therapy. The Reviewer commented that it is well known in our literature that at least 10% of patients with clinical evidence of peripheral nerve compression syndromes will have no evidence of this on normal electrodiagnostic studies.

Regarding ODG statements for simple nerve decompressions of the cubital tunnel vs. anterior subcutaneous ulnar nerve transposition, the Reviewer commented that these are "guidelines" for surgical criteria, not mandates based on the American Academy of Orthopaedic Surgeons (AAOS) or the American Board of Orthopaedic Surgery (ABOS) accepted surgical literature. The Reviewer cited the following reference: Green, Hotchkiss, Pederson, Wolfe: Greens's Operative Hand Surgery, Fifth Edition, Volume One.

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)**