PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 07/28/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left elbow loose body removal, left ulnar nerve decompression, and left wrist TFCC repair

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

Board Certified in Orthopedic Surgery
Fellowship Trained in Hand Surgery

REVIEW OUTCOME

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

X 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.

Left elbow loose body removal, left ulnar nerve decompression, and left wrist TFCC repair - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X-rays of the left elbow interpreted by , M.D. dated 09/14/07
Evaluations with , M.D. dated 09/18/07, 10/03/07, 10/17/07, 10/31/07, 11/07/07, 11/12/07, 11/19/07, 12/12/07, 02/05/08, and 03/12/08
DWC-73 forms from Dr. dated 09/18/07, 10/03/07, 11/19/07, 02/05/08, and 04/09/08
X-rays of the left upper extremity interpreted by Dr. dated 10/03/07
Physical therapy with , O.R., O.L.T. dated 10/23/07, 11/01/07, 11/06/07, 11/08/07, 11/14/07, 11/15/07, and 11/20/07
An evaluation with M.D. dated 12/10/07
A letter from , Claims Adjuster for Insurance Company, dated 01/16/08
Evaluations with Robert M.D. dated 04/09/08, 05/07/08, and 06/18/08
X-rays of the left upper extremity interpreted by Dr. r dated 04/09/08
X-rays of the skull interpreted by M.D. dated 04/09/08
An evaluation with , M.D. dated 04/23/08
An EMG/NCV study interpreted by Dr. dated 04/23/08
A short form history/physical from , R.N. dated 04/23/08
A left wrist arthrogram MRI interpreted by , M.D. dated 04/23/08
Precertification requests from Dr. dated 05/14/08, 05/15/08, and 06/02/08
Letters of denial, according to the ODG, from dated 05/21/08, 06/10/08, and 07/01/08
Letters from Dr. dated 05/28/08 and 06/18/08
A DWC-73 form from Dr. dated 06/18/08
The ODG Guidelines were not provided by the carrier or URA

PATIENT CLINICAL HISTORY

X-rays of the left elbow interpreted by Dr. on xx/xx/xx revealed a fracture of the left radial head. On 09/18/07, Dr. placed the patient in a left wrist gauntlet splint and prescribed Vicodin ES. On 10/17/07, Dr. prescribed Celebrex and physical therapy. Physical therapy was performed with Ms. from 10/23/07 through 11/20/07 for a total of seven sessions. X-rays of the left wrist interpreted by Dr. on 10/31/07 revealed healing of the fracture in acceptable alignment. On 12/10/07, Dr. recommended an MRI arthrogram of the left elbow, an EMG/NCV study of the left upper extremity, a possible left intrarticular injection, possible left wrist surgery, a compressive elbow pad and sleeve, and continued anti-inflammatories. On 12/12/07, Dr. recommended work hardening. On 04/09/08, Dr. recommended electrodiagnostic studies and an MRI arthrogram of the left wrist. X-rays of the skull interpreted by Dr. on 04/09/08 were unremarkable. A left wrist arthrogram MRI interpreted by Dr. on 04/23/08 revealed a distal radioulnar joint effusion and mild bone contusion of the distal ulna. An EMG/NCV study interpreted by Dr. on 04/23/08 revealed mild cubital tunnel syndrome and mild carpal tunnel syndrome. On 05/07/08, Dr. recommended surgery. On 05/21/08, 06/10/08,

and 07/01/08, I wrote letters of denial for left elbow and left wrist surgery. On 06/18/08, Dr. continued to recommend surgery.

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

In regard to the left ulnar nerve decompression, I largely agree with the treating physician in that the diagnosis of the cubital tunnel that requires surgical treatment is largely a clinical one and the EMG/NCV studies with cubital tunnel syndrome actually have a very high false/negative rate. However, there appears to be a lack of conservative treatment in this patient. Most patients should undergo at least a short trial of night splinting to see if this helps with the patient's symptoms. Many patients can avoid surgery with a course of night splinting. Thus, at this time, I do not believe an ulnar nerve decompression is necessary due to the lack of an attempt at conservative treatment.

Next, in regard to the TFCC injury, although the examination describes the TFCC tear, the examination also could be describing other diagnoses in the wrist. With the lack of objective evidence on the MRI of the TFCC tear or objective evidence by arthrogram for the TFCC tear, I think a clinician is obligated to perform the diagnostic injections of the wrist joints to see if the patient had pain abatement with a Cortisone injection for even a short period. In my opinion, doing arthroscopy at this point is not indicated due to the lack of diagnostic injections to confirm that an intrarticular procedure, i.e., a wrist arthroscopy, would be necessary.

With regard to the left elbow loose body removal, there is absolutely no evidence presented that there is a left elbow loose body. These are almost always seen on MRIs. The patient does have a history of a fracture; however, minimally displaced radial head fractures can actually mimic a loose body. Without confirmatory evidence that this is an actual loose body by imaging, in my opinion, the left elbow loose body removal is not indicated. Therefore, the requested left elbow loose body removal, left ulnar nerve decompression, and left wrist TFCC repair are neither reasonable nor necessary.

The criteria for these opinions are supported and found in the ODG Guidelines, especially the addressing of the TFCC injury. Treatment for this is well established in the hand and surgery literature, including *Green's Operative Hand Surgery*.

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 AND KNOWLEDGE BASE
- [ ] 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
- [x] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- [ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- [ ] MILLIMAN CARE GUIDELINES
- [x] 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)