

Notice of Independent Review Decision

**DATE OF REVIEW:** 06/02/2009

**IRO CASE #:**

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

Outpatient right ulnar nerve subcutaneous anterior transfer and right elbow capsulectomy with radius ulna and humerus osteotomy ulnar nerve subcutaneous anterior transfer.

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

The TMF physician reviewer is a board certified orthopedic/hand surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

**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.

It is determined that the outpatient right ulnar nerve subcutaneous anterior transfer and right elbow capsulectomy with radius ulna and humerus osteotomy ulnar nerve

subcutaneous anterior transfer is not medically necessary to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Information for requesting a review by an IRO – 05/19/09
- Decision letter – 05/14/09, 08/18/09
- Utilization Review Referral – 04/29/09
- Workers Compensation Patient Information Sheet – 05/14/08
- Report of Medical Evaluation – 04/23/09, 03/17/09
- Review of Medical History & Physical Exam – 03/17/09
- Office visit notes by Dr. – 05/15/08 to 04/23/09
- Operative note by Dr. – 08/19/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/xx when he was unloading and a 200 pound log fell from 5 feet high, hitting first his right hand then his right forearm. The patient has undergone a right elbow arthroscopy with loose body removal, joint debridement and right elbow anterior capsulectomy in August of 2008. He has significant limitation of range of motion and has been diagnosed with status post right elbow capsulectomy with persistent capsular contracture. The treating physician has recommended that the patient undergo outpatient right ulnar nerve subcutaneous anterior transfer and right elbow capsulectomy with radius ulna and humerus osteotomy ulnar nerve subcutaneous anterior transfer.

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

This patient has underlying osteoarthritis with pain and stiffness. This was aggravated by his workers compensation injury. He has undergone surgery and his range of motion is worse now than it was before the original surgery. There is no documentation to support the diagnosis of ulnar neuropathy and there was no evidence of osteophytes on the operative note from the original surgery. Therefore the necessity for performing a decompression and removal of osteophytes at this time has not been established. In addition, there is documentation to indicate questionable compliance with the patient's original post-operative regime and occupational therapy. Therefore, there is no reason to expect that the patient's symptoms would improve with a second 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 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)**