

SENT VIA EMAIL OR FAX ON  
Aug/09/2010

## Independent Resolutions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Aug/09/2010

**IRO CASE #:**

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

OP: Anterior Ulnar Neuroplasty to decompress ulnar nerve

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

Doctor of Medicine (M.D.)  
Board Certified in Orthopaedic Surgery  
Fellowship Training in Upper Extremities

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines  
Denial Letters 5/20/10 and 7/8/10  
OP Report 8/28/09  
Hospital 8/28/09 thru 9/1/10  
Bone and Joint 9/11/09 thru 6/14/10

**PATIENT CLINICAL HISTORY SUMMARY**

The patient has ulnar neuropathy at the elbow that has failed conservative management after a severe bilateral upper extremity injury requiring multiple surgeries. The patient has failed conservative management and has subluxation of the ulnar nerve at the elbow. Nerve conduction study confirms compression of the ulnar nerve at the elbow. Request for ulnar nerve transposition at the elbow has been denied twice by being insurance company because the reviewer stated that the request was for ulnar nerve decompression at the wrist, which is incorrect.

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

The request for anterior ulnar nerve transposition in this patient is medically reasonable and necessary. The ODG guidelines recommend ulnar nerve decompression for patients that have failed conservative management. The IRO reviewer disagrees with those guidelines recommendations for simple decompression, particularly in this patient. The studies used to support the simple decompression recommendation are poor studies and not generally accepted in the hand/upper extremity community. The request is medically reasonable and necessary.

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

ACOEM-AMERICA 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)  
(OKU SPINE)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)