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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/07/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lt Ulnar Nerve Transposition w/ Lengthening Outpt, 64718, 25280

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

M.D., 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 10/20/09, 11/23/09
Office note, Dr., 10/13/08
Office notes, Dr., 10/16/08, 11/06/08, 12/10/08, 01/21/09, 03/25/09, 04/22/09, 05/21/09, 06/25/09, 08/05/09, 09/02/09, 09/30/09
Left elbow x-ray report, 03/20/09
Electromyography report 04/08/09
RME, Dr. 08/12/09
Office note, Dr. 10/06/09
Office note, Dr. 10/20/09

PATIENT CLINICAL HISTORY SUMMARY

This is a male who fell on xx/xx/xx. The 10/13/08 left elbow x-rays showed no fracture. The 02/25/09 examination documented a healed surgical scar to the medial aspect of the left elbow. The 04/08/09 electromyography showed evidence of very mild non-localizing left ulnar sensory neuropathy that was at or proximal to the take off of the dorsal ulnar cutaneous sensory nerve. Dr. examined the claimant on 10/06/09 for complaints of left hand weakness, pain, and paresthesias. The claimant noted severe numbness and tingling in ring and small fingers. Examination revealed positive elbow flexion test, strongly positive Tinel over the ulnar nerve at the elbow, intrinsic hand grip of 4/5, and diminished sensation in the ulnar nerve distribution with the little and ulnar border of the ring finger. There was medial snapping consistent with hypermobile ulnar nerve. Diagnosis was left ulnar neuropathy at the elbow, moderate to severe with intrinsic hand weakness.

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

The electromyography of 04/08/09 did not actually localize the left ulnar neuropathy. A positive Tinel was documented by the RME in 08/09. The treating physician in 10/09 recommended surgical care as there had been failed extensive physical therapy. There

would appear to be a bit of a discrepancy in interpreting electrodiagnostics as Dr. suggested the nerve conduction studies confirmed compression of the ulnar nerve at the elbow.

In short the records provided do not clarify whether or not specific elbow or physical therapy and activity modification have been undertaken. The anti-inflammatory agents in duration are unclear. It is unclear if an elbow pad or night splint were used. Furthermore it is somewhat concerning that there is a healed scar along the medial elbow, clearly the site of the ulnar nerve. It is unclear whether or not this represents prior ulnar nerve surgery. There are no references to this in the medical records, other than documentation of the scar and there is no operative note in the prior procedure.

Taking all of this into account the reviewer does not believe the case meets medical necessity guidelines under the ODG. The reviewer finds that medical necessity does not exist at this time for Lt Ulnar Nerve Transposition w/ Lengthening Outpt, 64718, 25280.

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter elbow, simple decompression for cubital tunnel

ODG Indications for Surgery -- Simple Decompression (SD) for cubital tunnel syndrome: Initial conservative treatment, requiring ALL of the following

- Exercise: Strengthening the elbow flexors/extensors isometrically and isotonicly within 0-45 degree
- Activity modification: Recommend decreasing activities of repetition that may exacerbate the patient's symptoms. Protect the ulnar nerve from prolonged elbow flexion during sleep, and protect the nerve during the day by avoiding direct pressure or trauma
- Medications: Nonsteroidal anti-inflammatory drugs (NSAIDs) in an attempt to decrease inflammation around the nerve.
- Pad/splint: Use an elbow pad and/or night splinting for a 3-month trial period. Consider daytime immobilization for 3 weeks if symptoms do not improve with splinting. If the symptoms do improve, continue conservative treatment for at least 6 weeks beyond the resolution of symptoms to prevent recurrence.

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