

# US Resolutions Inc.

An Independent Review Organization  
1115 Weeping Willow  
Rockport, TX 78382  
Phone: (512) 782-4560  
Fax: (207) 470-1035  
Email: manager@us-resolutions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Dec/24/2009

**IRO CASE #:**

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

Right elbow arthroscopy

**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

**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**

Adverse Determination Letters, 12/1/09, 11/17/09  
DO, 11/11/09, 10/14/09, 9/1/09, 8/18/09, 8/12/09, 7/21/09, 7/17/09, 12/1/09 (Letter), 3/4/08 (Letter)  
Operative Report, 7/9/09  
ODG, does not address  
Textbook of Orthopaedics, Elbow Flexion Contracture/Stiff Elbow

**PATIENT CLINICAL HISTORY SUMMARY**

The patient underwent open reduction and internal fixation of a right supracondylar humerus fracture on xx/xx/xx. Despite extensive physical therapy and a home exercise program, the patient has a significant flexion contracture and extension contracture of the elbow. Range of motion is from 40 degrees to 90 degrees. The operating surgeon has requested an arthroscopic release in an attempt to restore functional range of motion.

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

There is no documentation of serial splinting, turnbuckle splinting, or dynamic splinting. Evidently, the fracture has healed. The request for surgery does not come with adequate documentation of complete conservative care such as the splinting mentioned above. In addition, the physical therapy documentation has not been provided either. The request is not medically reasonable or necessary based on the medical records provided by the provider. The reviewer finds that medical necessity does not exist at this time for Right elbow arthroscopy.

**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)

Wheeless' Textbook of Orthopaedics, Elbow Flexion Contracture/Stiff Elbow  
Green's Operative Hand Surgery, Fifth Edition

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