

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 06/09/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left ulnar nerve transposition between 04/16/2010 and 06/15/2010

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 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 left ulnar nerve transposition is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 05/18/10
- Letter of Determination from xxxx – 04/23/10, 04/30/10, 05/06/10
- Initial Injury Treatment Report – 08/24/09
- Office visit notes by Dr.– 08/24/09 to 01/08/10
- X-ray report of left elbow – 08/24/09
- Report of nerve conduction study – 09/01/09
- Letter from Dr. to Worker's Compensation – 04/02/10
- Copy of ODG Guidelines Elbow Chapter – n date
- Physical Therapy Daily Progress Notes – 04/12/10 to 04/22/10
- Rehab Therapy Evaluation & Plan of Care – 04/12/10
- Review Determination Letter from xxxxx – 05/06/10

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he fell from a truck resulting in injury to the left ulnar nerve of the left elbow. An EMG and nerve conduction study revealed ulnar nerve injury in the cubital tunnel. The patient continues to have weakness in his grip, extension, intrinsic hand muscle, especially abduction, adduction of the left hand. He continues to have numbness and tingling in the ring finger of the left hand. The treating orthopedic surgeon is recommending that the patient have surgical intervention in the form of an ulnar nerve transposition.

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

This patient has failed conservative non-operative treatment. He has had rest, worn an arm sling and undergone physical therapy. The examination performed on 04/02/2010 indicates pain, numbness and tingling into his hand. There are also documented indications of weakness on abduction and adduction, a weak grip and weak extension of his left hand with wasting of the hypothenar muscle. Therefore, it is determined that the ulnar nerve transposition is medically necessary to treat this patient's condition.

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)

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