



Notice of Independent Review Decision

**DATE OF REVIEW:** 08/08/11

**IRO CASE #:**

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

Outpatient hardware removal, manipulation left shoulder / wrist / fingers / elbow

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., Board Certified in Orthopedic Surgery

**REVIEW OUTCOME:**

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED FOR REVIEW:**

1. Certificate of Independence of the Reviewer.
2. Letters of denial 6/17, 7/5 & 07/21/11, including the criteria used in the denial.
3. Treating doctors evaluation and follow up exams, including radiology reports 03/22/11 – 07/12/11.
4. Operative report 2/23/11-open reduction w/internal fixation of left elbow olecranon fracture & excision of radial head fragments & replacement w/radial head prosthesis.
5. Physical therapy progress notes 5/19/11 through 6/1/11 (6 visits).

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
337.2			Prosp.						Upheld

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The patient suffered an olecranon and radial head fracture that was repaired with ORIF of the ulna and radial head replacement. She developed CRPS after surgery and was sent for stellate

ganglion blocks with a pain management specialist. The surgeon has recommended hardware removal and multiple joint manipulations under anesthesia.

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

The basis for the requested procedures appears to be pain and stiffness. The medical records provided do not adequately demonstrate medical necessity for these procedures. The effects of the stellate ganglion blocks were not documented well. The hardware has not been properly established as this patient's pain generator. Finally, wrist, elbow, and hand manipulations have not been shown to be effective in this type of case. There is no demonstration of dynamic splinting or serial casting either. The request is not medically reasonable or necessary.

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

*(Check any of the following that were used in the course of your review.)*

- 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 judgment, 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 national accepted medical literature (provide a description). OKU Hand / Wrist.
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)