



Notice of Independent Review Decision

DATE OF REVIEW: 12/30/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right Ulnar Nerve Subcutaneous Anterior Transfer Outpatient

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

Board Certified in Orthopedic Surgery
Fellowship Trained in Hand 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)

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.

Right Ulnar Nerve Subcutaneous Anterior Transfer Outpatient – OVERTURNED

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- New Patient Evaluation, M.D., 04/16/10
- Established Patient Evaluation, Dr. 08/27/10
- New Patient Consultation, M.D., 10/06/10
- EMG Report, M.D., Ph.D., 10/10/10
- Follow Up Report, Dr. 10/27/10, 10/28/10
- Denial Letter, 11/04/10, 11/22/10

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient sustained a fracture of her right distal radius and apparently some fractures around the elbow. She was initially treated with a cast for seven weeks and then progressed to a brace. She was referred to physical therapy. An EMG was performed which demonstrated no neurophysiologic evidence of carpal tunnel syndrome, C5-T1 cervical radiculopathy, right ulnar neuropathy, radial neuropathy, musculocutaneous neuropathy, or brachial plexopathy on either side. The patient had been treated with Norco, Lodine, Aspirin, and Darvocet. A right ulnar nerve subcutaneous anterior transfer was requested.

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

This patient has had symptoms of right ulnar nerve entrapment. This is confirmed by EMG. Per the records reviewed, the patient has failed conservative treatment including activity modifications, exercises/therapy, medications, and bracing. Thus, in accordance with ODG Guidelines, I believe the patient is a candidate for a decompression procedure, and a subcutaneous anterior transfer is certainly an adequate surgery for that.

In my medical opinion, I agree with the need for surgery.

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)
- AMA 5TH EDITION