

US Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Dec/27/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right ulnar nerve Transposition

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

10/25/10, 10/8/10
Orthopaedic Associates, LLP 9/3/10 to 10/4/10
Rehabilitation Medical Specialists, P.A. 9/7/10
10/25/10, 10/8/10
Physical Therapy 8/5/10 to 8/30/10
systems 7/12/10 to 8/10/10
M.D. 9/7/10
Official Disability Guidelines Treatment in Workers' Compensation

PATIENT CLINICAL HISTORY SUMMARY

The patient complains of constant numbness in the right ulnar nerve distribution after hitting his elbow on the bed of a pickup truck at work. The patient was seen by the requesting surgeon and sent for a nerve conduction study. EMG was negative and nerve conduction study showed slowing of the ulnar nerve around the elbow. Radiographs revealed degenerative changes in the elbow. Ulnar nerve transposition was recommended by the surgeon and denied by the insurance company.

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

Although this patient may ultimately require ulnar nerve transposition, the documentation

provided does not support surgery at this time. There is no documentation by the requesting surgeon that the patient has failed an adequate trial of conservative treatment including padding, occupational therapy, and supported medication. In addition, there is no documentation of a home exercise program. As such, the request for Right ulnar nerve Transposition is not medically necessary at this point in time.

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: Green's Operative Hand Surgery, 5th Edition

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