



MedHealth Review, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: 6/2/11

IRO CASE #:

Description of the Service or Services In Dispute

The item in dispute is the prospective medical necessity of a right elbow ulnar nerve decompression with partial epicondylectomy (64718).

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a right elbow ulnar nerve decompression with partial epicondylectomy (64718).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Dr., Mr. and Carrier.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr.: 4/7/11 to 5/10/11 follow up notes by orthopedics clinic and 8/31/10 neurodiagnostic report.

Carrier: 5/12/11 denial letter, 3/17/11 to 4/7/11 follow up notes by Clinic

Mr: 5/19/11 letter by Mr, 9/23/10 to 3/17/11 follow up notes from Clinic, handwritten exam notes from unknown party dated 1/6/11, Clinic notes 12/15/10 to 3/29/11, 3/4/11 operative report, 8/12/10 initial eval by Clinic, 11/12/09 neurodiagnostic report, 1/6/11 RME report by MD, follow up consult by Clinic 9/2/10, 9/22/10 letter by MD, various DWC 73 forms, 9/23/09 to 10/7/10 notes from Clinic, 8/20/09 to 11/17/09 pt notes from Clinic, 12/15/09 to 7/9/10 WC reports by DO, 11/25/09 referral script, 1/18/10 pt referral form and 1/8/10 cervical MRI report.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a XX year of age female injured worker whose date of injury is XX/XX/XX. The only right elbow exam findings submitted were from 3/17/11. She has had elbow pain with paresthesias into the small and ring fingers. (The claimant was noted to have done well with a similar procedure to the left elbow procedure.) Tenderness and a positive Tinel's sign were noted at the right elbow. 11/12/09 dated NCV studies revealed a right median neuropathy and DSEPs revealed a right C7 radiculopathy. Electrical studies from 8/31/10 were noted to reveal no clear evidence of neuropathy. Diagnoses were noted to include ulnar neuritis and medial epicondylitis. A cervical MRI dated 1/8/10 revealed cervical stenosis at C5-6 and C6-7.

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

The electrical studies did not corroborate the clinical diagnosis. Also, without clearly documented recent evidence of failure of a comprehensive non-operative treatment program, the proposed surgical treatment would not be reasonable or necessary at this time.

ODG Indications for Surgery -- Simple Decompression (SD) for cubital tunnel syndrome: Initial conservative treatment, requiring ALL of the following:

- Exercise: Strengthening the elbow flexors/extensors isometrically and isotonicly within 0-45 degrees
- Activity modification: Recommend decreasing activities of repetition that may exacerbate the patient's symptoms. Protect the ulnar nerve from prolonged elbow flexion during sleep, and protect the nerve during the day by avoiding direct pressure or trauma.
- Medications: Nonsteroidal anti-inflammatory drugs (NSAIDs) in an attempt to decrease inflammation around the nerve.
- Pad/splint: Use an elbow pad and/or night splinting for a 3-month trial period. Consider daytime immobilization for 3 weeks if symptoms do not improve with splinting. If the symptoms do improve, continue conservative treatment for at least 6 weeks beyond the resolution of symptoms to prevent recurrence.

As noted above, the patient has not met the indications/criteria for surgical intervention as per the records reviewed. Therefore, the requested procedure is not medically necessary at this time.

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)