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IRO Certificate #

Notice of Independent Review Decision

DATE OF REVIEW: 6/24/11

IRO CASE #:

Description of the Service or Services In Dispute
Left elbow ulnar nerve transposition and long arm splint

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

Physician Board Certified in Orthopedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

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

Description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Information Provided to the IRO for Review
ODG guidelines
Adverse determination letters 5/4/11, 4/19/11
Clinical notes, Dr. 3/2010-4/2011
RME report, Dr. 2/14/11
Electrodiagnostic testing reports, 11/9/10, 4/6/10
Radiology report 3/17/10
MRI report 3/10/11
FAE report 6/25/10

PATIENT CLINICAL HISTORY [SUMMARY]:

In XX/XXXX, the patient was driving and was hit by another vehicle and had multiple injuries, most of which apparently have improved. He continues to have numbness, tingling, in his fourth finger and had an extensive amount of treatment including a physical therapy and medications. He has two diagnostic studies demonstrating ulnar nerve involvement. Surgery has been suggested by the treating surgeon.

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

I disagree with the denial of the nerve transposition and the long arm splint. This individual had a injury resulting in the clinical presentation of a ulnar nerve palsy. Two electrodiagnostic studies confirm findings of ulnar nerve involvement. He has had extensive physical therapy time, medications, and has not significantly improved. By reported physical examination and diagnostic studies, this patient has ulnar nerve palsy. Ulnar transposition has been suggested. The choice of procedure by the treating surgeon is medically reasonable.

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)