

SENT VIA EMAIL OR FAX ON
Jun/21/2011

P-IRO Inc.

An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #203
Mansfield, TX 76063
Phone: (817) 405-0878
Fax: (214) 276-1787
Email: resolutions.manager@p-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jun/20/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left arthroscopic release and removal of loose body, left elbow; and Ulnar nerve neurolysis transposition

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

MD board certified orthopedic surgery

REVIEW OUTCOME:

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

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

Left arthroscopic release and removal of loose body, left elbow are medically necessary.
Ulnar nerve neurolysis transposition is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

1. Pre-authorization review determination 05/04/11 regarding adverse determination left arthroscopic release, removal of loose body, left elbow; and ulnar nerve neurolysis transposition
2. Pre-authorization determination 05/23/11 regarding adverse determination appeal request left arthroscopic release, removal of loose body, left elbow; and ulnar nerve neurolysis transposition
3. Office notes Dr. 12/13/10 through 04/28/11
4. EMG/NCV report 04/06/11
5. Physical therapy daily progress note 01/31/11
6. Office notes Dr. 10/19/10 and 12/09/10
7. CT left elbow 10/14/10
8. MRI left elbow 10/08/10
9. X-rays left elbow 10/07/10
10. Office notes Dr. 10/06/10
11. X-rays left elbow 10/04/10

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a XX year old male whose date of injury is XX/XX/XX. He was injured when he fell off the back of a truck. He reported injuring his elbow, hip and head. The injured employee was diagnosed with a left radial head fracture. He was initially splinted and referred for physical therapy. Electrodiagnostic testing performed 04/06/11 was reported as an abnormal study with evidence of a subacute denervation of the muscles innervated by the left ulnar nerve distal to the flexor carpi ulnaris. In absence of conduction velocity slowing or conduction blocking the left ulnar nerve, this could be consistent with a traumatic injury to the ulnar nerve. There also is electrodiagnostic evidence of a subacute left C6 cervical radiculopathy.

A pre-authorization request for left arthroscopic release, removal of loose body left elbow, and ulnar nerve neurolysis transposition was reviewed and determined as non-certified on 05/04/11. The history documented the claimant fell out of his truck landing on his left elbow and sustaining a left radial head

fracture and evulsion fracture of the humerus. X-rays on 10/04/XX showed a large avulsed fracture fragment that appeared to arise from the olecranon, questionable non-displaced fracture of the radial neck and joint effusion. The claimant complained of left elbow and wrist pain with intermittent tingling. Examination showed pain with pronation and supination of the left elbow, decreased range of motion, moderate swelling, tenderness laterally over the radial head and over the distal radial ulnar joint (DRUJ) and slight crepitus at the DRUJ. Left elbow x-rays on 10/07/XX showed a comminuted radial head fracture, displaced fracturing of the fragment into the anterior aspect of the joint and a joint effusion. Left elbow MRI dated 10/08/XX revealed radial head fracture, findings suggestive of a common extensor tendon evulsion injury with associated marrow edema of the lateral condyle, moderate sized joint effusion with anterior recess cortical bone fragment measuring 9x14mm with additional low signal intensity bodies or hemorrhagic blood product in the anterior and posterior recesses. Non-displaced fracture of the coronoid process of the proximal ulna and partially visualized radial collateral ligament poorly visualized lateral ulnar collateral ligament. The injured employee was noted to be treated with bracing, splinting and therapy. Injection was given on 01/05/11 from the lateral soft spot. The injured employee reported very little improvement despite aggressive therapy and injection. Left elbow contracture was diagnosed and the injured employee was to continue with restrictions. Most recent examination dated 03/16/11 noted 47-95 degrees of active flexion and 90 degrees of rotation. Electromyography studies on 04/13/11 showed a left ulnar neuropathy proximal to the enervation of the flexor digitorum profundus without evidence of demyelinating component, consistent with trauma. There also was evidence of a left subacute C6 cervical radiculopathy. The review noted that Official Disability Guidelines regarding surgery for cubital tunnel syndrome recommend simple decompression and surgical transposition of the ulnar nerve is not recommended at all. The review further noted that Campbell's operative orthopedics notes that removal of loose bodies is most common indication for elbow arthroscopy. When symptoms of pain, catching and limited motion persist a thorough arthroscopic examination is indicated. In this case, no mechanical symptoms were documented. Primary concern was elbow stiffness. Indications to release an elbow contracture for stiffness include lack of a functional range of motion to the elbow from 30-130 degrees of flexion. In this case only 95 degrees of active flexion was documented. The injured employee was noted to have failed appropriate bracing, splinting and therapy. While it was noted the injured employee may benefit from ulnar nerve surgery and elbow contracture release surgery, guidelines do not support ulnar nerve transposition surgery and therefore the proposed left elbow arthroscopic release, removal of loose body, and ulnar nerve transposition surgery would not be considered medically necessary or appropriate.

An appeal request for arthroscopic release, removal of loose body left elbow, and ulnar nerve neurolysis transposition was reviewed on 05/23/11 and adverse determination was recommended. The reviewer spoke with the requesting provider who acknowledged that the injured employee has cubital tunnel syndrome and he would be satisfied with pre-authorization for cubital tunnel release without transposition of the ulnar nerve. The reviewer noted that the requesting provider abruptly discontinued the conversation during the reviewer's concern for application of a dynasplint prior to pre-authorizing arthroscopic surgery of the elbow joint for contracture release. Noting that the reviewer was unable to obtain verbal agreement to modify the primary request for surgical pre-authorization, the request as submitted was recommended for adverse determination.

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

Based on the clinical information provided, the proposed arthroscopic release and removal of loose body left elbow is indicated as medically necessary. The injured employee sustained a left radial head fracture when he fell from the back of the truck. The injured employee failed to improve with conservative care including bracing, splinting and therapy as well as injection. There is objective evidence on electrodiagnostic testing consistent with traumatic injury to the ulnar nerve. There is evidence of a displaced bone fragment seen on x-ray and MRI of the left elbow. Records note that the injured employee demonstrated limited range of motion and was diagnosed with left elbow contracture. Given the current clinical data, arthroscopic release and loose body removal is indicated as medically necessary. Simple decompression of the ulnar nerve also is supported per Official Disability Guidelines. However there is no medical necessity for transposition of the ulnar nerve as Official Disability Guidelines recommend simple decompression without ulnar nerve transposition unless the ulnar nerve subluxes on range of motion of the elbow.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES