



## IMED, INC.

11625 Custer Road • Suite 110-343 • Frisco, Texas 75035  
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584  
e-mail: imeddallas@msn.com

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### Notice of Independent Review Decision

**DATE OF REVIEW:** 05/20/11

**IRO CASE NO.:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Item in dispute: Appeal 24346-Left Elbow Medial Collateral Ligament Reconstruction  
Request Received Date 04/04/2011

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

Texas Board Certified Orthopedic Surgeon  
Texas Board Certified Orthopedic Sports Medicine

**REVIEW OUTCOME**

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

Denial Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. 02/01/11 - Clinical Note - M.D.
2. 02/07/11 - CT Left Elbow
3. 02/08/11 - Clinical Note - M.D.
4. 02/08/11 - Radiographs Chest
5. 02/09/11 - Operative Report
6. 02/15/11 - Clinical Note - M.D.
7. 02/22/11 - Clinical Note - M.D.
8. 03/01/11 - Clinical Note - M.D.
9. 03/22/11 - Clinical Note - M.D.
10. 04/01/11 - Utilization Review
11. 04/05/11 - Laboratory Report
12. 04/11/11 - Utilization Review
13. 04/26/11 - Clinical Note - M.D.
14. 04/26/11 - Physical Therapy Prescription

15.05/09/11 - Letter -

16.05/11/11 - Correspondence - Law Offices

**17.Official Disability Guidelines**

**PATIENT CLINICAL HISTORY (SUMMARY):**

The employee is a female who sustained an injury on xx/xx/xx when she tripped on the leg of a sofa and fell forward on the floor.

The employee saw Dr. on 02/01/11 with complaints of left elbow pain. Physical examination revealed tenderness to palpation at the anterior capsule and fracture site. There was swelling at the anterior capsule, fracture site, and radial head. The skin ecchymosis was resolving. There was crepitus noted at the fracture site. There were abrasions noted. There was no sign of skin mottling. There was no evidence of dystrophic changes of the skin. There was no cutaneous hypersensitivity present. Radiographs of the left elbow demonstrated a fracture of the coronoid process. The fracture was comminuted. There was an osteochondral fracture of the capitellum. There was a significant articular surface step off and irregularity present. The fragments were maligned. The radial head was fractured. The fracture fragments were minimally displaced. The employee was assessed with elbow pain, fracture of the coronoid process, fracture of the lateral condyle, fracture of the radial head, and lateral dislocation of the elbow. The employee was recommended for a CT of the elbow.

A CT of the left elbow performed 02/07/11 demonstrated complete dislocation of the elbow with the radius and ulnar posteriorly displaced relative to the distal humerus. There was a fracture of the radial head. There were fracture fragments in the fluid distended elbow joint, compatible with displaced fracture fragments. There was no gross evidence for an ulnar or humerus fracture identified. There was no osseous mass or bony erosion seen.

The employee underwent left elbow open reduction, radial head replacement, and lateral ligament reconstruction as well as extensor mass reconstruction on 02/09/11.

Postoperative radiographs of the left elbow performed 02/09/11 demonstrated a radial head prosthesis. The alignment appeared satisfactory and the osseous structures appeared intact.

The employee was seen for postoperative evaluation on 03/01/11. Physical examination revealed no tenderness to palpation. There was no swelling and the skin ecchymosis was resolving. There were no signs of infection, erythema, or cellulitis. Radiographs of the left elbow revealed radial head replacement noted with minor subluxation of the joint. The employee was assessed with elbow pain, fracture of the coronoid process, fracture of the lateral condyle, fracture of the radial head, and lateral dislocation of the elbow. The employee was recommended for physical therapy.

The employee saw Dr. on 03/22/11. The employee stated she felt the complaints for which she originally sought treatment were now resolved. The employee did describe an aching sensation with some weakness and occasions of subluxation. Physical examination revealed no tenderness to palpation. There was no swelling and the skin ecchymosis was resolving. There are no signs of infection, erythema, or cellulitis. The employee was assessed with elbow pain, fracture of the coronoid process, fracture of the radial head, lateral dislocation of the elbow, and medial collateral ligament sprain. The employee was recommended for medial collateral ligament reconstruction and physical therapy.

The request for left elbow medial collateral ligament reconstruction was denied by utilization review on 04/01/11 as no postoperative imaging studies were submitted for review to assess the employee's left elbow pathology. There was no indication the employee had a medial collateral ligament tear to warrant surgical intervention at this time.

The request for left elbow medial collateral ligament reconstruction was denied by utilization review on 04/11/11 as the employee stated her complaints had resolved and she was feeling better. There was no documentation of clear clinical and electrophysiologic or imaging evidence of a lesion that had been shown to benefit in both the short and long-term from surgical repair.

The employee saw Dr. on 04/26/11 with complaints of left elbow pain and weakness. Physical examination revealed tenderness to palpation at the elbow with extension and medial epicondyle. There was swelling present at the medial epicondyle. The skin ecchymosis was resolving. The medial collateral ligament stress test in extension and flexion was positive and unstable. Range of motion revealed extension to 30 degrees, flexion to 120 degrees, pronation to 50 degrees, and supination to 50 degrees. There were no signs of infection, erythema, or cellulitis. There was healthy granulation tissue present. The employee was assessed with elbow pain, fracture of the coronoid process, fracture of the lateral condyle, fracture of the radial head, medial collateral ligament sprain, and lateral dislocation of the elbow. The employee was recommended for medial collateral ligament reconstruction and physical therapy.

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

The requested left elbow medial collateral ligament repair is not recommended as medically necessary. There are positive examination findings for laxity and instability of the left elbow. Typically imaging would be used to identify a medial collateral ligament reconstruction; however, in this case imaging would be limited secondary to the hardware in place. CT studies would not reasonably identify ligament pathology. As this is not evident in the clinical records, medical necessity for the requested surgical procedures is not established.

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

**Official Disability Guidelines** Elbow Chapter does not directly address elbow medial collateral ligament reconstruction.

Marc J. Richard, MD<sup>1</sup>, J. Mack Aldridge, III, MD<sup>2</sup>, Ethan R. Wiesler, MD<sup>3</sup> and David S. Ruch, MD: Traumatic Valgus Instability of the Elbow: Pathoanatomy and Results of Direct Repair. *The Journal of Bone and Joint Surgery (American)*. 2008;90:2416-2422.