



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

04/28/2011

DATE OF REVIEW: 04/28/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right ulnar nerve transposition

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

Texas State Licensed MD Board Certified Orthopedic Surgeon

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)

Provide a 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

1. Texas Dept of Insurance Assignment to Medwork 04/11/2011
2. Notice of assignment to URA 02/28/2011 04/11/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 04/08/2011
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 04/06/2011
6. notice 03/29/2011, pre-auth 03/24/2011, notice 03/09/2011, pre-auth 03/03/2011, notice 02/18/2011, pre-auth 02/14/2011, medicals 03/14/2011, 03/01/2011, chart notes various dating 2009-2010, medicals 01/07/2011, 12/29/2010, 12/15/2010, 03/24/2010, 01/22/2010
7. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

This is a patient who sustained injury on xx/xx/xx to the right elbow while at work. Patient complains of pain. Records indicate a MRI scan was carried out and results are normal and an EMG of both upper extremities is normal as well. Review request is for right ulnar nerve transposition.



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

Referring to the Official Disability Guidelines recommendations along with the review records, this patient does not fulfill the criteria for the requested right ulnar nerve transposition. The review records show that the MRI scan is normal and the EMG results are normal. The review records are insufficient and do not support the Official Disability Guidelines recommendation for the requested right ulnar nerve transposition; therefore, the insurer's decision to deny is upheld.

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 KNOWLEDGBASE
- 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)