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Notice of Independent Review Decision

DATE OF REVIEW: October 4, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

DME for Left Elbow Hinged Range of Motion Brace. CPT Code: None.

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

DIPLOMATE, AMERICAN BOARD OF ORTHOPAEDIC SURGERY
FELLOW, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY:

To Whom It May Concern:

I have had the opportunity to review medical records on this patient. The records indicate a date of injury of xx/xx/xx, and include a reported injury to the left arm.

The initial medical record is dated August 26, 2010, 25 days following the incident. The records indicate that the patient was a male who injured the bilateral elbows at work on August 1, 2010. The patient was riding on a Segway which crashed and flipped over, landing on top of him. The patient fell on both outstretched hands, sustaining fractures to both elbows.

The patient was initially treated at Medical Centers. The patient reports improvement in his pain at that time. X-rays were reviewed and disclosed a non-displaced coracoid fracture, as well as a radial head fracture of both elbows. M.D., opined that the fractures would have required surgery, but the

patient was four weeks out from the injury and he did not feel that surgery would further improve his condition. Dr. recommended physical therapy for range of motion.

Physical therapy was begun under Dr. supervision. The patient's symptoms did not improve, and a CT scan was ordered.

On October 4, 2010, the CT scan disclosed mildly displaced bilateral comminuted fractures of the radial head. Dr. recommended surgery.

On November 10, 2010, Dr. performed prosthetic replacement of the right radial head. Physical therapy was begun following the surgery.

On January 5, 2011, Dr. performed prosthetic replacement of the radial head on the left. Physical therapy was prescribed for that.

The patient had continued complaints, and a CT scan was ordered.

On April 8, 2011, the CT scan revealed prosthetic replacement of the radial head on the right side without complications.

Dr. however, reviewed the CT and opined that it disclosed heterotopic ossification. Dr. recommended surgery.

On May 25, 2011, Dr. performed arthrotomy and excision of heterotopic ossification. Physical therapy was again recommended.

The patient returned on June 28, 2011. The patient had bilateral elbow pain and crepitus. The patient was developing numbness of his ulnar digits on the right side. Dr. noted good range of motion and no ligamentous instability. There was a functional capacity evaluation recommended.

On July 15, 2011, the patient underwent a functional capacity evaluation. The patient qualified for the medium physical demand level, which exceeded the light physical demand level required of his job description.

On July 28, 2011, Dr. opined that the patient had reached maximum medical improvement. Dr. assigned a 16% impairment rating. A review of his report indicates the rating was performed on the basis of ulnar nerve impairment and radial head arthroplasty. There was a hinged range of motion brace subsequently recommended, and it was non-certified by the carrier. The rationale for the non-certification was the documented range of motion of 3-130 degrees. There were no ODG Guidelines for a hinged elbow brace.

The patient returned to Dr. on August 23, 2011. Dr. noted no evidence of infection with severe tenderness over the lateral epicondyle. There was no instability noted. Dr. opined a diagnosis of radial head fractures and tardy ulnar nerve syndrome. Dr. recommended electrodiagnostic studies. X-rays disclosed no abnormalities.

Attorney, wrote a letter dated September 12, 2011. There was an IRO being requested based upon the denial of the hinged elbow brace.

The final entry into the medical record is dated September 15, 2011, and is a letter from Dr. Dr. noted the request for a left elbow hinged range of motion brace. The purpose of the brace was for persistent pain in the elbow and limitations in range of motion. Dr. reported that the patient had "severe tenderness over the lateral epicondyle, and there was some popping sensation in his right elbow. The patient felt as if his elbow was giving way." Dr. opined that the purpose of the brace was to help increase range of motion and to improve stability.

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

A hinged elbow brace is not medically necessary. There is no evidence of instability in this case, and at this late date from surgery, a range of motion brace is not likely to improve extension. The letter of medical necessity reported by Dr. on September 15, 2011, does not include a specific brace. Dr. simply indicates that a "hinged elbow brace can help with the range of motion." There is no medical indication in this case for a hinged elbow brace.

I trust that this will be sufficient for your needs.

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)