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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/16/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Radial Head ORIF VS and Right Radial Head Replacement

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

Orthopedic surgery

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 medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who sustained an injury on xx/xx/xx when she sustained trauma to the right arm resulting in right radial neck fracture. MRI of right elbow dated 04/12/12 revealed a transverse nondisplaced fracture of right radial head with surrounding bone edema of proximal radius. The claimant was placed on light duty and right upper extremity was splinted. Clinical evaluation on 05/01/12 by Dr. stated the patient continued to report pain in right upper extremity. Physical examination at this visit revealed near full range of motion in right elbow with flexion to 130 degrees. Extension was limited only to 5 degrees. Pronation was noted. Radiographs performed in clinic demonstrated a nondisplaced fracture of radial neck. Radiographs of the right shoulder completed on 05/08/12 revealed moderate acromioclavicular joint arthrosis. Follow-up with Dr. on 06/05/12 stated the patient continued to have right elbow pain. Physical examination revealed full range of motion with some limitations on pronation and supination. Repeat radiographs of right upper extremity revealed persistent non-union of radial head without interval healing. Follow-up on 06/26/12 stated the patient continued to have pain in right elbow radiating into the right shoulder. Physical examination at this visit revealed loss of range of motion in right shoulder with continued limited pronation and supination of right elbow. There was a positive mechanical click with pronation and supination of right elbow. The patient was recommended for physical therapy and anti-inflammatories for the right shoulder. The patient was also recommended for open reduction internal fixation or replacement of radial head for persistent nonunion. Follow-up on 07/20/12 revealed no new findings in right elbow. The claimant was continued on anti-inflammatories. A note by Dr. on 07/25/12 indicated the patient would need CT of right elbow to determine status of nonunion.

The request for right elbow internal fixation versus radial head replacement was denied by

utilization review on 06/13/12 as there is limited clinical information to support the request. The request was again denied by utilization review on 07/26/12 due to lack of comments regarding interval healing. During peer-to-peer conversation suggested therapies such as CT scans or repeat radiograph studies as well as possible intraarticular injections.

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

Based on the clinical information provided, the request for open reduction internal fixation of right elbow versus radial head replacement is not recommended as medically necessary. The clinical documentation submitted for review did not adequately address the most recent rationale for denial. The clinical documentation did not include any new updated imaging studies of right elbow that demonstrated persistent nonunion of the proximal radial head fracture. It is unclear if other therapies were provided to the patient as discussed in peer-to-peer conversation noted in prior denial. Given lack of new updated imaging studies of right elbow demonstrating persistent nonunion of right radial head fracture, medical necessity cannot be established at this time.

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

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

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES