

Notice of Independent Review Decision

**DATE OF REVIEW: 01/25/2012**

**IRO CASE #:**

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

Right elbow radial head replacement revision, possible lateral ulnar collateral

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

The physician performing this review is Board Certified, American Board of Orthopedic Surgery. He has been in practice since 1998 and is licensed in Texas, Oklahoma, Minnesota and South Dakota.

**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.

Upon independent review, the reviewer finds that the previous adverse determinations should be overturned

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records Received: 19 page fax 01/05/12 Texas Department of Insurance IRO request, 65 pages of documents received via fax on 1/09/12 URA response to disputed services including administrative and medical. Dates of documents range from 08/18/11 to 01/05/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient is a right-hand-dominant male who was injured xx/xx/xx while driving . He apparently was checking the thermal unit on top of the truck when he slipped and fell. He ultimately ended up with what sounds like an open fracture with comminution of the radial head. He has had two surgeries, including a radial head replacement on 09/20/11. He continues to have limited elbow range of motion and is not able to extend his arm past 90 degrees. He has had additional physical therapy, which again has not allowed him to progress with his range of motion.

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

Based on the ODG guidelines, It is clear that the patient underwent appropriate surgical treatment for the fracture but has had a poor outcome with documented instability of the elbow as well as documented subluxation and malalignment of the implanted device. At this point, it is felt that revision of the previous surgery with revision of the implant and perhaps reconstruction of the ulnar collateral ligament is the only opportunity for this patient to achieve a more functional elbow.

The opinions rendered in this decision are based upon review of the medical records and all judgments made upon the records available for review. I have not had the opportunity to meet or examine this patient or to review the imaging studies described.

**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)