

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jun/11/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Neuroplasty and transposition of the ulnar nerve at left arm

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

M.D., Board Certified 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines

Request for IRO dated 05/22/10

Utilization review determination dated 05/09/12

Utilization review determination dated 05/15/12

Clinic note Dr. 02/28/12 and 05/01/12

Radiographic report left forearm 02/28/12

Radiographic report left elbow dated 2/28/12

EMG/NCV study dated 04/09/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained work related injuries to his left upper extremity on xx/xx/xx. He was involved in motor vehicle accident resulting in crush injury of left upper extremity. He is noted to have comminuted fracture, distal radius and ulna, which was complicated by compartment syndrome with median and radial nerve involvement. He underwent ORIF of distal radius and ulna, release of forearm compartment where subsequent exploration of nerve into wrist with large volar skin graft. Postoperatively the claimant is noted to have significant sensory deficit in left hand. He underwent EMG/NCV study on 04/09/12 which showed a mild to moderate left carpal tunnel syndrome. Per clinic notes there was some evidence to suggest PIN compression neuropathy. When seen in follow-up on 05/01/12 the claimant continues to have complaints of pain in dorsum of left forearm and numbness and tingling in median nerve distribution of left hand. It is reported previous EMG/NCV showed compressive neuropathy in radial nerve in forearm at level of elbow. He is reported to be unimproved with nonoperative management. The claimant received an anesthetic block over the region of the radial neck where PIN crosses. He is reported to have had relief of pain over the radial tunnel. The initial review was performed on

05/09/12 by Dr.. Dr. non-certified the request noting that surgery for cubital tunnel syndrome is recommended for simple decompression and in most cases transposition is not required. He notes at this point in time there is no indication the claimant has cubital tunnel syndrome, and EMG/NCV does not show electrodiagnostic evidence of cubital tunnel syndrome. Therefore, he non-certified the request. A subsequent appeal request was reviewed on 05/15/12 by Dr.. Dr. denied the request. He used Official Disability Guidelines regarding cubital tunnel syndrome. The claimant has had injection with temporary relief. He indicates the requestor was recommending posterior interosseous nerve release, which would require positive electrodiagnostic study of radial nerve pathology, which has not been documented.

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

There is no substantive corroborative data to establish the claimant has evidence of cubital tunnel syndrome. Electrodiagnostic studies were negative. There is no detailed exam, which establishes the claimant has positive findings attributed to ulnar nerve at elbow. As such, the reviewer finds the patient would not meet criteria per Official Disability Guidelines for Neuroplasty and transposition of the ulnar nerve at left arm. The reviewer finds there is not a medical necessity for Neuroplasty and transposition of the ulnar nerve at left arm. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

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

ACOEM-AMERICA 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)