SENT VIA EMAIL OR FAX ON
May/29/2012

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
May/29/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
1 Left Cubital Tunnel Release; 1 Left Wrist Arthroscopic Triangular Fibrocartilage Complex

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
General Surgery
Fellowship trained Orthopedic Hand and Upper Extremity Surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Request for IRO dated 05/09/12
Utilization review determination dated 04/17/12
Utilization review determination dated 04/24/12
MRI shoulder dated 05/11/11
Clinical records Dr. dated 08/17/1-09/21/11
Report of medical examination dated 10/17/11
Clinical records Dr. dated 12/08/11
Clinical records Dr. dated 02/01/12-04/11/12
Electrodiagnostic studies dated 02/01/12
MRI left wrist dated 02/15/12
Procedure report dated 03/05/12
Clinic note Dr. 03/22/12
Operative report dated 03/26/12

Clinic note Dr. dated 04/03/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained work related injuries on xx/xx/xx when he fell off back of truck falling approximately 4 feet. It is reported his pant leg got caught in a bungee cord hook. He landed on his left shoulder, arm, and left knee and lower leg. The claimant is noted to have history of prior arthroscopic surgery to his left knee on 03/18/11, 1 month prior to the injury. Records indicate the claimant came under the care of Dr.. He has complaints of left shoulder, elbow, left knee, and left chin pain. He is tender over medial epicondyle and non-tender over lateral epicondyle, non-tender over olecranon and anteriorly. He has full range of motion, negative Tinel's at elbow, good grip strength, and good hand intrinsic strength. He has normal sensation in medial and radial nerve distributions. He was subsequently referred for physical therapy. He is noted to have significantly elevated left knee pain. On 09/21/11 he received a corticosteroid injection into area of medial epicondyle. On 02/01/11 the claimant was seen by Dr. with complaints of left elbow and wrist pain. He has tenderness over the medial condyle. He has increased pain with forward wrist flexion and pain with supination and pronation. He is noted to have positive elbow flexion test, negative Tinel's, and positive ulnar grind. Strength is decreased in forearm. He has decreased sensation in ulnar distribution. Reflexes are intact. He is referred for therapy and electrodiagnostic studies which opined presence of mild to moderate left ulnar neuropathy. These findings were felt to be consistent with a typical demyelinative and later axonal pathophysiology of ulnar neuropathy and tardy ulnar palsy. There was evidence of a mildly active L5 lumbar radiculopathy. The claimant was referred for MRI of the left wrist on 02/15/12. This study notes a suspected perforation repair of the TFCC. This was not demonstrated with certainty. MRI arthrogram of the wrist would provide a more definitive assessment. Records indicate that the claimant underwent an intraarticular injection to the wrist on 03/05/12. He was subsequently taken to surgery on 03/26/12 at which time he underwent medial and lateral meniscectomies of the left knee. When seen in follow-up on 04/11/12 the claimant's last injection to the elbow is reported to have worked for a month or last injection is reported to have worked for a month. He was recommended to undergo a left wrist scope and cubital tunnel syndrome surgery.

The initial request was reviewed by Dr. on 04/17/12 who non-certified the request noting that the medical records submitted do not provide any documented evidence of failure to respond to the recommended conservative treatment such as oral pharmacotherapy, injections, and physical medicine. He notes there are no physical therapy records documenting the lack of progress throughout several attempts. A subsequent appeal request was reviewed by Dr. on 04/24/12 who non-certified the appeal request due to a lack of documentation regarding failure of conservative treatment. He notes that there were no serial physical therapy progress notes and no documentation regarding optimized oral pharmacotherapy and subsequently upholds the prior determination.

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

The request for left cubital tunnel release, left wrist arthroscopic triangular fibrocartilage complex repair is not supported as medically necessary. And the prior utilization review determinations are upheld. The submitted clinical records indicate that the claimant sustained multiple injuries as the result of a trip and fall from the rear of the truck. He is noted to have sustained injuries to the left knee, left shoulder, wrist, and elbow. The records do not provide data establishing focused treatment to the left elbow which would include oral medications, physical therapy, and splinting/bracing. In the absence of detailed clinical information indicating that the claimant has exhausted all conservative management, the request cannot be certified as medically necessary and the prior utilization review determinations are deemed appropriate.

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

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

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)