

# Prime 400 LLC

An Independent Review Organization  
8760 A Research Blvd., #241  
Austin, TX 78758  
Phone: (530) 554-4970  
Fax: (530) 687-9015  
Email: manager@prime400.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Sep/26/2012

**IRO CASE #:**

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

Left Ulnar Nerve Transposition

**A 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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** The reviewer finds medical necessity does not exist for Left Ulnar Nerve Transposition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines

Adverse determination notice 08/06/12

Adverse determination after reconsideration notice 08/22/12

Response to request for IRO

Notice of disputed issue and refusal to pay benefits 03/28/07

Peer review

Peer review

Office visit notes

Consultation/electrodiagnostic study reports 06/05/12, 08/24/10 and 01/30/07

X-rays bilateral wrists 01/29/02

Operative reports 03/26/02 12/17/02 05/17/07 and 10/14/10

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female. The mechanism of injury is not described, but the claimant is noted to have a history of bilateral carpal tunnel problems, with EMG/NCV studies that revealed very advanced bilateral carpal tunnel problems. Claimant has undergone multiple surgical procedures including right carpal tunnel release 03/26/02, left carpal tunnel release 02/17 or 12/17/02, revision carpal tunnel release 05/17/07, and revision right carpal tunnel release 10/14/10. Records indicate the claimant underwent rotator cuff surgery in 12/11 and reports worsening of sensation of numbness in the fourth and fifth digits of the left hand following surgery. She notes when applying pressure to the elbow numbness is increased. She also

notes numbness if she sleeps with her elbow flexed. She has weakness in both hands. Electrodiagnostic testing performed 06/05/12 reported abnormal left median conduction study with findings consistent with mild to moderate left carpal tunnel syndrome; abnormal left ulnar conduction study with findings consistent with segmental ulnar neuropathy at the elbow or cubital tunnel syndrome. Claimant was seen in follow up on 07/02/12 after undergoing EMG/NCV of the left upper extremity which documented substantial carpal tunnel and pretty severe conduction block of the ulnar nerve at the elbow. She was noted to need carpal tunnel revision and ulnar nerve transposition.

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

Claimant is noted to have sustained an injury. She has a history significant for bilateral carpal tunnel syndrome, and has undergone multiple surgical procedures including right and left carpal tunnel release and revision carpal tunnel release. Most recent electrodiagnostic testing performed 06/05/12 revealed findings consistent with mild to moderate left carpal tunnel syndrome as well as findings consistent with ulnar neuropathy at the elbow/cubital tunnel syndrome. Records do not document that the claimant has had an appropriate course of conservative care for the left elbow such as exercise, activity modification, anti-inflammatory medications and elbow pad/night splint. There also is no indication on clinical examination of subluxation of the ulnar nerve. Per Official Disability Guidelines, simple decompression is recommended for cubital tunnel syndrome in most cases. Surgical transposition of the ulnar nerve is not recommended unless the ulnar nerve subluxes on range of motion of the elbow. Based on the records reviewed and the ODG, the reviewer finds medical necessity does not exist for Left Ulnar Nerve Transposition.

**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)**