

# Core 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Dec/26/2013

IRO CASE #:

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** outpatient neurolysis radial nerve pin; debridement epicondyle, posterior inteross

**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.** It is the opinion of the reviewer that the request for outpatient neurolysis radial nerve pin; debridement epicondyle, posterior inteross nerve is not recommended as medically necessary.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines  
Office Visit 9/20/2013  
Clinical notes 10/23/13  
Adverse determinations 10/30/13 and 11/12/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who reported an injury to his right elbow from an unknown origin. Notes indicate the patient complaining of lateral epicondylitis and findings indicating radial tunnel syndrome. The patient underwent epidural steroid injection at the lateral aspect of the elbow with significant improvement. Pain continued over the proximal aspect of the forearm which was radiating to the wrist and dorsal aspect of the hand. The patient rated the pain as minimal when at rest and severe with activities. Weakness was noted at the hand. Upon exam no visible deformities were noted at the right forearm. Pain was noted with pressure over the peripheral interosseous nerve and at the dorsal aspect of the forearm at the junction of the proximal third and middle third. Pain was moderate at the lateral epicondyle. The patient had positive provocative maneuvers. Utilization review dated 10/30/13 resulted in a denial for an operative procedure as no information was submitted regarding exhaustion of all conservative care. Utilization review dated 11/12/13 resulted in denial for the requested operative procedure as no information was submitted regarding completion of any conservative treatment. No prior electrodiagnostic studies were submitted.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** Clinical documentation submitted for review notes the patient complaining of left and right forearm pain. Radial nerve neurolysis would be indicated provided that the patient meets specific criteria, including completion of all

conservative treatment. Clinical notes mention previous injection at the right elbow. However, no other information was submitted regarding previous completion of any conservative treatment stretched a home exercise program or bracing. It is noted that physical therapy was ordered. Additionally, no electrodiagnostic studies were submitted confirming the patient's pathology. As such, it is the opinion of the reviewer that the request for outpatient neurolysis radial nerve pin; debridement epicondyle, posterior inteross nerve is not recommended as medically necessary.

**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)