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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X

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

REVIEW OUTCOME:

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

☐ Overturned Disagree

☐ Partially Overturned Agree in part/Disagree in part

☒ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

• X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. Per the utilization review adverse determination letter dated X, the mechanism of injury was X. The diagnosis was Z48.89 (encounter for other specified surgical aftercare). No office visits, imaging reports or treatment to date were provided in the available records. Per a utilization review adverse determination letter, with request complete date X, by X, MD, the request for X was denied. Rationale: "This is a request for a claimant X. The injury occurred on X. The reported mechanism of injury was X. This resulted in a left elbow anterior dislocation. This is a request for X. The diagnosis included left cubital tunnel syndrome. No comorbidities were noted. There was a complaint of left-sided elbow pain with continued stiffness and difficulty with reaching. Physical examination of the left upper extremity notes well-healed incisions of the shoulder. There was a X in Tinel's test, and the sensation was intact. Range of motion of the left double was measured from X degrees through X degrees. A nerve conduction study noted findings consistent with cubital tunnel syndrome. Previous treatment for the left elbow had included X. The Official Disability Guidelines supported surgical intervention for cubital tunnel syndrome for those with corresponding symptoms of paresthesias in the X and X fingers and corresponding objective findings on physical examination and electrodiagnostic testing. There should be failure to improve with conservative treatment to include splinting and medication. Current progress notes for this claimant did not include any complaints of neuropathic symptoms of the X and X fingers of the hand and physical examination did not note any abnormal sensation. Additionally, guidelines did not support manipulation under anesthesia procedure or corresponding lysis of adhesions for conditions of the elbow. It may be considered for recurrent stiffness following surgery; however, no surgery was performed. This request for X is not supported. Recommend non-certification. "Per a reconsideration review adverse determination letter, with request complete date X, by X, MD the request for X was denied. Rationale: "The claimant has been

diagnosed with X. The left elbow MRI arthrogram report from X, shows a partial thickness tear of the ulnar collateral ligament, edema of the common flexor tendon insertion, prominent muscle edema in the pronator teres, and thickening of the ulnar nerve proximal to and within the cubital tunnel. There is a clinical note from X, documenting a visit with X, MD. The claimant reports left elbow pain, and numbness and tingling in the fourth and fifth digits. The treatment has included X. There are no pertinent comorbidities noted. The surgical history includes a X. The nerve study from X, shows slowed conduction velocity of the ulnar nerve at the elbow. Objectively, there is left elbow 10-15-degree extension deficit, flexion of 90 degrees, positive Tinel's at the X, and decreased sensation in the X. As the symptoms have been refractory to conservative treatment, the provider is recommending surgical management. The ODG conditionally recommend surgery for cubital tunnel syndrome after at least three months of conservative treatment when there is persistent pain, sensory loss or paresthesia involving the fourth and fifth fingers and when there are corroborating objective and electrodiagnostic test findings. Transposition of the ulnar nerve is not recommended unless the nerve clearly and painfully subluxes during motion. The ODG does not generally recommend manipulation under anesthesia except for a second-line option for recurrent stiffness only following surgery. In this case, the claimant has been diagnosed with X. The MRI and electrodiagnostic study are consistent with these diagnoses. The examination shows a positive Tinel's at the X, and extension deficit of X degrees, and flexion restricted to X degrees. There have been persistent symptoms despite prior conservative treatment including X. Considering the extensive conservative treatment, proceeding with surgery would be appropriate as further nonoperative management would not be expected to provide meaningful or lasting benefit. While the documentation does not indicate that the request is for X. Addressing the concomitant range of motion restrictions is appropriate and standard of care as failure to do so would result in a worse overall prognosis. There were no exceptional factors to support transposition of the ulnar nerve as the documentation does not indicate that there is clear and painful subluxation. As such, X is medically necessary; however, X is not medically necessary. However, as I was unable to reach the treating physician to discuss treatment modification, the request remains not certified at this time. The recommendation is for non-certification of the request for X followed by X.
“Based on the case summary provided, the requested surgical procedure remains noncertified. No medical records were provided for the independent review.

Therefore, no new information has been provided which would overturn the previous denials. X is not medically necessary and non-certified.

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

Based on the case summary provided, the requested surgical procedure remains noncertified. No medical records were provided for the independent review. Therefore, no new information has been provided which would overturn the previous denials. X is not medically necessary and non-certified.

Upheld

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

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL