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DATE OF REVIEW: 06-15-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy - Right Elbow 4xWk x 4Wks

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

Certified by the American Board
General Certificate

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)

Injury Date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturn
xx/xx/xx	xxxxxx-xxxxxx	Prospective	841.9	97110	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notice of Adverse Determinations 05-29-07 and 06-07-07
 Physician Examination Notes dated xx/xx/xx, 12-20-06, and 02-14-07
 Report Summary For Functional Capacity Evaluation (FCE) 05-24-07
 Physical Therapy Examination 01-29-07
 Upper Extremity Electrodiagnostic Study 09-26-06
 MRI of the Right Elbow 10-11-06

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant was injured at work on xx/xx/xx involving the right arm. The claimant sustained right epicondylitis as a result of the injury. As the claimant did not respond to usual non-operative treatment, a "Tennis Elbow Release" was performed on 01-29-07. The surgical incision was well healed after 2 weeks, and physical therapy was started on 03-02-07. After 19 post operative physical therapy visits, it was noted that the claimant had not met goals of range of motion and strength, along with medial elbow paresthesia, on an extensive evaluation on

IRO NOTICE OF DECISION - WC

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05-24-07. The treating physician recommended 16 additional physical therapy visits, which was denied as not medically necessary for this claimant.

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

I agree that additional physical therapy is not medically necessary. Rather, the claimant should be on a home therapy program.

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 KNOWLEDGBASE
- 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)