

# Independent Resolutions Inc.

An Independent Review Organization

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## IRO REVIEWER REPORT TEMPLATE -WC

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### **DATE OF REVIEW:**

*June 8, 2007*

### **IRO CASE #:**

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

*Physical Therapy-97140, 97112- for dates of service.*

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

*DOCTOR OF CHIROPRACTIC-11years practicing in the Texas Worker's Comp system as a level II treating doctor; injury prevention consultant for*

### **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 or not medical necessity exists for each of the health care services in dispute.

*97112-Physical Therapy—not medically necessary*

*97140-Physical Therapy—not medically necessary*

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

*Cervical spine X-rays from Hospital, treatment notes.*

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

*This is a female who works as a. She stated she injured herself pulling on her bag several times to release it from something it was caught. She stated she immediately felt severe right elbow pain.*

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

*Given the date of injury, and the diagnosis of Lateral Epicondylitis, the treatments along with the dates of service that are in dispute are not reasonable or medically necessary. This is an inflammatory diagnosis that is associated with a sprain/strain that is a self limiting diagnosis. Treatment per is longer than necessary treatment along with a self directed home exercise program. Therefore, according to the below referenced criteria, the treatment and the dates of service in dispute are not reasonable or medically necessary.*

**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
- 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)