



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 09/19/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient lateral release of the right elbow

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

Board Certified in Orthopedic Surgery
Fellowship Trained in Hand 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 or not medical necessity exists for each of the health care services in dispute.

Outpatient lateral release of the right elbow - Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An MRI of the right elbow interpreted by M.D. dated 12/14/06
A referral form from an unknown provider (the signature was illegible) dated 12/19/06
Evaluations with M.D. dated 12/26/06, 01/30/07, 03/12/07, 04/16/07, 06/04/07, and 07/16/07,
A Functional Capacity Evaluation (FCE) with D.C. dated 05/16/07
Evaluations with Dr. dated 05/17/07 and 06/27/07
DWC-73 forms from Dr. dated 05/17/07 and 06/27/07
An impairment rating evaluation with Dr. dated 05/21/07
A DWC-73 form from Dr. dated 06/04/07
A preauthorization request from Dr. dated 07/19/07
A letter of non-certification from M.D. according to the Official Disability Guidelines (ODG), dated 07/24/07
A letter of appeal from Dr. dated 07/25/07
A letter of non-certification, according to the ODG, from M.D. dated 08/02/07
A request for a hearing dated 08/30/07

PATIENT CLINICAL HISTORY

An MRI of the right elbow interpreted by Dr. on 12/14/06 revealed lateral epicondylitis with partial tearing of the common extensor tendon. On 12/26/06 and 04/16/07, Dr. performed a lateral epicondyle injection. On 03/12/07, Dr. recommended Ketoprofen cream and an epicondylar strap. Based on an FCE with Dr. on 05/16/07, the patient was to return to modified work duty. On 05/21/07, Dr. placed the patient at Maximum Medical Improvement (MMI) with a 6% whole person impairment rating. On 06/04/07, Dr. performed another elbow injection. On 07/16/07, Dr. recommended right elbow surgery. On 07/19/07, Dr. provided a preauthorization request for surgery. On 07/24/07, Dr. wrote a letter of non-certification for right elbow surgery. On 07/25/07, Dr. wrote a letter of appeal for the surgery. On 08/02/07, Dr. wrote a letter of non-certification for the surgery.

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

The patient has had the symptoms for over a year. Not only have the symptoms been present for over a year, but the patient has failed all forms of conservative management, including bracing, non-steroidal anti-inflammatory medications, a home exercise program, supervised physical therapy, and Cortisone injections on a number of occasions. This patient failed all reasonable forms of conservative treatment. The ODG is quite clear in this case and the patient has continued with persistent symptoms despite conservative treatment for a reasonable amount of time are qualified for surgery. Therefore, the requested outpatient lateral release of the right elbow is reasonable and 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 AND KNOWLEDGE BASE
- 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)