Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 10/6/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of OT 2x4 with laser treatment (laser therapy and kinesiotape); 97003, 97112, 97110, 97140, 97035, 97530, and G0283.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a board certified physical medicine and rehabilitation physician with greater than 10 years of experience in this field.

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)

Medical necessity for the laser therapy is approved. All other modalities and procedures are denied as not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties:
Dr.
These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr.: office visit notes – 1/30/06 - 6/17/08; report – 1/4/06; Occupational Therapy Referral – 5/28/08; Systems Discharge Summary – 2/16/06, 7/21/06, & 4/19/07, Upper Extremity Evaluation – 3/26/07, Plan of Care – 2/3/06, 6/27/06, & 7/11/06, and Hand and Upper Extremity Referral – 1/31/?? & 6/7/08.
Records reviewed from: denial 6/3/08 & 6/17/08; pre-authorization – 5/29/08, 2nd request – 6/10/08.

A copy of the ODG was not provided for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient was injured on xx/xx/xx while performing duties. She has a diagnosis of lateral epicondylitis of the elbow. She received injections and at least 20 visits of OT.

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

The ODG notes laser therapy is recommended as an option for lateral epicondylitis using a narrowly defined LLLT regimen where lasers of 904 nm wavelength with low output (5–50 mW) are used to irradiate the tendon insertion at the lateral elbow using 2–6 points or an area of 5 cm2 and doses of 0.25–1.2 Joules per point/area. Not recommended using wavelengths of 820, 830 or 1064 nm, or higher doses or higher power, or using irradiation of trigger points or irradiation of acupuncture points. The available material suggests that LLLT is safe and effective, and that LLLT acts in a dose-dependent manner by biological mechanisms that modulate both tendon inflammation and tendon repair processes. With the recent discovery that long-term prognosis is significantly worse for corticosteroid injections than placebo in lateral epicondylitis, LLLT irradiation with 904 nm wavelength aimed at the tendon insertion at the lateral elbow is emerging as a safe and effective alternative to corticosteroid injections and NSAIDs. LLLT also seems to work well when added to exercise and stretching regimens. There is a need for future trials to compare adjunctive pain treatments such as LLLT with commonly used pharmacological agents. A recent meta-analysis concluded that low level laser therapy (LLLT) administered with optimal doses of 904 nm and possibly 632 nm wavelengths directly to the lateral elbow tendon insertions, seem to offer short-term pain relief and less disability in lateral elbow tendinopathy (LET), both alone and in conjunction with an exercise regimen. This finding contradicts the conclusions of previous reviews that failed to assess treatment procedures, wavelengths and optimal doses. Before this study, there was good evidence showing laser therapy and pulsed electromagnetic field therapy to be ineffective in the management of lateral epicondylitis. Only limited evidence was shown for treatment of lateral elbow tendinopathy. Some limited results suggested that polarized, polychromatic, non-coherent, low energy light (Bioptron) could reduce patients' symptoms with acute tennis elbow; future controlled studies are needed to establish its relative effectiveness.

A review of the ODG fails to reveal any evidence to support or deny the utilization of kinesio taping procedures for this diagnosis. Secondly, the remainder of the OT visits have met the maximum amount of approvable OT sessions for this injury. While it is true that the ODG recommends the laser treatment with further exercise and stretching protocols. This patient has had enough of this type of protocol in office and should be able to perform the procedures in a home based program at this point.

Therefore, only the laser therapy is approved as requested and all other modalities and procedures are denied.

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)**