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DATE OF REVIEW: 6/7/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Additional Physical Therapy Left Upper Extremity

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

Certified by the Texas Board of Chiropractic Examiners

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination 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/ Overturned
xx-xx-xx		Prospective	728.85		Upheld
xx-xx-xx		Prospective	726.32	L3999	Upheld
xx-xx-xx		Prospective	354.9	97010	Upheld
xx-xx-xx		Prospective	923.03	97110	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Practitioner notes/evaluations dated 4/24/09, 4/16/09, 3/13/09, 1/27/09

Physical therapy notes dated 8/25/08, 8/27/08

Official Disability Guidelines cited but not provided-ODG Elbow Physical Therapy guidelines, ODG Preface Physical Therapy

PATIENT CLINICAL HISTORY:

This claimant sustained a contusion to the left upper extremity on xx-xx-xx when struck by a child. Evaluation and treatment included EMG/NCS studies, medications, and physical therapy. The claimant was evaluated by multiple physicians and certified at maximum medical improvement (MMI).

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

The ODG treatment guidelines does not support manipulative therapy for complaints of the upper extremity related to contusion (923.03). There is no recommendation for physical therapy related to contusion. For lateral epicondylitis (726.32), physical therapy is recommended for 10 sessions. In this case, the claimant has received the recommended physical therapy and has reached a point of MMI. The Reviewer noted that there was no remarkable objective evidence of a significant injury in the records provided.

In the Reviewer's opinion, the requested 12 additional sessions of physical therapy is not reasonable and not medically necessary as related to ODG treatment guidelines. Further, there was no remarkable objective finding in this case that would support the requested treatment as related to the injury that occurred over a year ago.

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)**