SENT VIA EMAIL OR FAX ON
Jul/26/2010

True Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Jul/14/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
JAS Elbow unit rental X 3 months

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board certified in Physical Medicine and Rehabilitation with expertise in pain management, wound management and geriatrics. Medical Director of Rehabilitation.

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[ ] Upheld (Agree)
[ ] Overturned (Disagree)
[X] Partially Overturned (Agree in part/Disagree in part)

The rental is medically necessary.
3 months are not medically necessary.
8 weeks are medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Denial Letters 4/19/10, 6/3/10, 6/21/10
Active Systems 12/15/09 thru 6/9/10
Literature No Date
IMRO 4/6/07 and 1/8/07
MCMC 1/19/07

PATIENT CLINICAL HISTORY SUMMARY
This worker fell off a truck on xx/xx/xx. X-rays showed a left elbow radial head fracture. He was splinted. He did have weakness in the extremity. There is a history of alcoholism. He did return to work without restrictions as it is a desk job. He began physical therapy. On 1/20/2010 there was 147 degrees flexion and he lacked 26 degrees of extension. On 3/16/10 he had 140 degrees of flexion and lacks 12 degrees of extension. On 4/10/10 he has 135 degrees of flexion and lacks 20 degrees of extension. He received a device for static stretch and on 4/20/2010 had gained to 145 degrees flexion and lacked 19 degrees to extension.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION
The ODG pain chapter on elbow p. 218 indicates static progressive stretch therapy is appropriate if there are established contractures when passive ROM is restricted. This patient was losing range of motion. The ODG does recommend this type of therapy for up to

8 weeks. The IRO reviewer's medical assessment is that 8 weeks use of this device is medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[ ] ACOEM-AMERICA 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)