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Amended Letter

**Notice of Independent Review Decision
Notice of Independent Medical Review Decision
Reviewer's Report**

DATE OF REVIEW: July 26, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

A male patient has requested coverage for 12 physical therapy sessions between 6/21/10 and 8/20/10.

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

M.D., Board Certified in Physical Medicine and Rehabilitation.

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)

I have determined that 8 physical therapy sessions over 5 weeks with emphasis on a home exercise program are medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 7/1/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Medical Review Organization (IRO) dated 7/2/10.
3. TDI Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 7/2/10.
4. TDI Notice to IRO of Case Assignment dated 7/5/10.
5. Letter from Utilization Review Unit with attached case file documentation received 7/6/10.
6. ODG Guidelines
7. Letter from DO dated 9/16/09.
8. Office notes from DO dated 10/21/09 and 6/14/10.
9. Request for Treatment Authorization dated 6/21/10, 6/25/10, and 7/2/10.
10. Prescription form for physical therapy dated 6/14/10.

11. Patient Summary Form dated 6/16/10.
12. Disabilities of the Arm, Shoulder and Hand dated 6/16/10.
13. Plan of Care dated 6/16/10.
14. Initial Evaluation dated 6/16/10.
15. Denial documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured at work on xx/xx/xx when he was, twisting his right elbow. He felt a jarring sensation. Immediately afterward, he lifted a ladder and the patient noted pain in the entire right upper extremity with an inability to use the muscles of the right cervical region and scapular region. He attempted to continue to work but the pain became worse causing nocturnal pain and paresthesias into his middle finger. When he failed to obtain relief, an orthopedic consult was performed. The patient was given an injection of steroids in the lateral epicondyle. An EMG was requested and the patient was placed on no work restrictions and given a wristlet to wear. On follow-up, the orthopedist notes state that the EMG identified a mild case of carpal tunnel syndrome. The patient was diagnosed with lateral epicondylitis. He received therapy and was not seen again for the right upper extremity injury until 6/14/10. Twelve physical therapy services between 6/21/10 and 8/20/10 were requested. The Carrier denied this request indicating that the disputed services are not medically necessary for treatment of the patient's right forearm injury.

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

For the diagnosis of lateral epicondylitis, the treatment recommendation by Official Disability Guidelines (ODG) is as follows:

“Recommended. Limited evidence. As with any treatment, if there is no improvement after 2-3 weeks the protocol may be modified or re-evaluated...patients who report nerve symptoms are more likely to experience a poorer short-term outcome after PT management of lateral epicondylitis....A recent clinical trial found that, after 12 months, the success rate for physical therapy (91%) was significantly higher than injection (69%), but only slightly higher than in the wait-and-see group (83%). (Korthals-de Bos, 2004).”

General ODG Physical Therapy Guidelines recommend up to 3 visits contingent on objective improvement documented (i.e., VAS improvement of greater than 4) and further trial visits with fading frequency up to 6 contingent on further objectification of long-term resolution of symptoms, plus active self-directed home physical therapy. For the treatment of epicondylitis, ODG Physical Therapy Guidelines indicate that medical treatment should consist of 8 visits over 5 weeks except in the post-surgical setting which provides for 12 visits over 12 weeks.

In the case of this patient, his injury occurred on x/x/xx. He was treated until 11/11/09 and improved to the point that he did not seek medical treatment again until 6/14/10. Because of the greater than 6 month absence of treatment for his right arm injury, his diagnosis at this time should be recurrent lateral epicondylitis. ODG does not address injuries that re-occur. It is medically reasonable and appropriate to treat the patient's condition as a re-injury to the right lateral epicondylitis. As such, the patient should be treated with physical therapy for 8 visits over

5 weeks with emphasis on training for a home program. Accordingly, a portion of the requested physical therapy services are medically necessary for treatment of the patient's medical condition.

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)