

SENT VIA EMAIL OR FAX ON
Jun/03/2010

Pure Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jun/03/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

PT 3 X 4 Left Elbow

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
Denial Letters 5/3/10 and 5/13/10
Emergency Service 2/2/10 thru 5/25/10

PATIENT CLINICAL HISTORY SUMMARY

This is a man who developed left elbow pain. There is no description of the injury. There was medial pain and a diagnosis of medial epicondylitis was made. Xrays were normal. He had an MRI that reportedly showed thickening of the common extensor tendon origin at the lateral epicondyle. No MRI report was provided. He had local tenderness that the physical therapist/chiropractor sometimes said involved the lateral epicondyle as well. Grasp was reduced. There was no initial improvement, then the pain resolved and then recurred after an injection by Dr.. This was not explained and could have been a corticosteroid. His pain level was initially 8 and finished at 10 after 13 therapy sessions. Mr., the PA, ordered additional 12 sessions of therapy on 5/25/10

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

There is a soft tissue problem along the medial elbow. The mechanism of injury was not provided. The diagnosis is both medial epicondylitis and sprain/strain. The ODG permits 8/9 therapy sessions from 5-8 weeks pending the diagnosis. He completed 12 without improvement. There was no improvement described. The request was for additional therapies without any explanation how they would help or differ from what has been

unsuccessfully tried. There is no medical justification in these circumstances for the medical necessity of the requested services.

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

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)