



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 05/04/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Nine Occupational Therapy Visits Over Three Weeks for the Left Elbow/Hand

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

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Nine Occupational Therapy Visits Over Three Weeks for the Left Elbow/Hand -
UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Evaluation, M.D., 12/09/09, 02/02/10, 02/24/10, 03/16/10
- Operative Report, Dr., 12/14/09
- Therapy Referral, Dr., 02/02/10, 03/16/10
- Hand/Upper Extremity Evaluation, O.T.R., 02/05/10, 03/18/10
- Pre-Authorization Request, Dr., 02/08/10, 03/19/10, 03/26/10
- Denial Letter, , 03/23/10, 03/26/10, 03/31/10
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient had medial and lateral epicondylitis and carpal tunnel. He underwent a left carpal tunnel release, left medial epicondylar debridement, left lateral epicondylar debridement and removal of small bone spur at olecranon. After the surgery, he underwent occupational therapy.

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

Additional occupational therapy for the left hand/elbow does not appear to be reasonable or necessary.

Based on the records reviewed, the Official Disability Guidelines would not provide for additional treatment sessions for the lateral or medial epicondylitis or carpal tunnel syndrome. The patient has completed the requisite eight sessions of therapy, and based upon the re-evaluation by the therapist post-operatively, the claimant actually retrogressed with therapy and lost both range of motion and strength. No objective medical documentation by the treating physician has been provided requiring additional therapy sessions and, therefore, this request cannot be certified.

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)**