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**Notice of Independent Review Decision
IRO REVIEWER REPORT – WC (Non-Network)**

DATE OF REVIEW: 09/13/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy three times a week for four weeks for the right elbow

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

Board Certified in Orthopedic Surgery

Fellowship Trained in Hand 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)

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.

Physical therapy three times a week for four weeks for the right elbow - Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with, D.O. dated 05/03/10, 05/07/10, 05/17/10, 05/24/10, 07/05/10

An operative report from Dr. dated 05/11/10

A physical therapy evaluation with P.T. dated 05/26/10

physical therapy progress notes with Mr. dated 06/22/10 and 07/27/10

Preauthorization request forms for physical therapy from Dr. dated 07/06/10, 07/28/10, and 08/04/10

A letter of adverse determination, according to the Official Disability Guidelines (ODG), from, M.D. dated 07/09/10

A letter of non-certification, according to the ODG, from, M.D. dated 08/03/10

A letter "To Whom It May Concern" from Mr. dated 08/18/10

A prescription for Ultram and Motrin from Dr. dated 08/18/10

The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On 05/03/10, Dr. recommended surgery and continued Ultram. On 05/11/10, Dr. performed an open reduction internal fixation of the right capitellum or condyle in the right elbow and right epicondyle. On 05/17/10, Dr. recommended physical therapy, Ultram, and a hinged elbow brace. On 06/22/10, Mr. stated the patient had been limited

by decreased number of insurance visits and recommended therapy two to three times a week for four more weeks. On 07/05/10, Dr. recommended physical therapy three times a week for four weeks with a Dynasplint. On 07/09/10, Dr. wrote a letter of adverse determination for physical therapy three times a week for four weeks. On 08/03/10, Dr. also wrote a letter of adverse determination for physical therapy three times a week for four weeks. On 08/18/10, Mr. wrote a letter of appeal for the physical therapy. On 08/18/10, Dr. prescribed Ultram and Motrin.

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

Based on the medical documentation provided for review, the patient continues to have deficits in her range of motion in the right elbow. Although she has made gains in the therapy provided thus far, she still, according to his 07/05/10 note from Dr., lacks 20 to 25 degrees of full extension and was flexing to about 90 degrees. This note also documents she has contractures at this time. X-rays performed that day revealed the elbow and its fixation were in good position and there was no header topic bone and no other complicating factors. Therefore, in my opinion, at this time, the requested physical therapy three times a week for four weeks is reasonable and necessary and the previous adverse determinations should be overturned.

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 AND KNOWLEDGE BASE
- 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)