

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 06/27/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

97110 Physical Therapy Left Elbow 2x wk x8 wks
97140 Manual Therapy Left Elbow 2x wk x8 wks
97112 Neuromuscular Re-education Left Elbow 2x wk x 8wks
97530 Therapeutic Activities Left Elbow 2x wk x 8wks

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

The TMF physician reviewer is board certified in orthopedic surgery with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that:

97110 Physical Therapy Left Elbow 2x wk x8 wks; 97140 Manual Therapy Left Elbow 2x wk x8 wks; 97112 Neuromuscular Re-education Left Elbow 2x wk x 8wks; 97530 and Therapeutic Activities Left Elbow 2x wk x 8wks are not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained an injury to the left arm and wrist on xx/xx/xx. She has suffered pain in the left wrist, left forearm and left elbow. MRI scans have confirmed TFCC tear of the left wrist and lateral epicondylitis of the left elbow. She has been treated with splinting of both the wrist and the elbow. Anesthetic and corticosteroid injections have been performed. Wrist symptoms appear to have improved. Elbow symptoms appear to be persistent. There is a request for physical therapy twice weekly for 8 weeks including CPT codes 97110 (general physical therapy code), 97140 (manual therapy), 97112 (neuromuscular re-education), and 97530 (Therapeutic activities).

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

Although there are no specific therapy progress notes, there is a physical therapy evaluation. The request for physical therapy twice weekly for 8 weeks exceeds the ODG recommendation for physical therapy as a result of lateral epicondylitis. The justification for physical therapy for a diagnosis of lateral epicondylitis arising from an injury approximately x months ago has not been documented. Therefore, the necessity for physical therapy in excess of that recommended in the ODG, 2011, elbow chapter has not been established.

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)