

P-IRO Inc.

An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #203
Mansfield, TX 76063
Phone: (817) 405-0878
Fax: (214) 276-1787
Email: resolutions.manager@p-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Sep/25/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Therapy 3 X wk for 4 weeks for 12 more sessions

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

General Surgery
Fellowship trained Orthopedic Hand

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 medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Independent medical evaluation 02/15/12
Operative report 04/30/12
Clinical notes 08/09/12
Clinical notes 08/15/12
Occupational therapy notes 08/17/12
Prior reviews 08/23/12 and 09/04/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an injury on xx/xx/xx and is status post ulnar nerve release in 10/09. The patient continued to have ongoing pain post-operatively and was assessed with chronic pain. The independent medical evaluation dated 02/15/12 did not recommend further physical therapy. The patient underwent a right elbow debridement of the extensor carpi radialis brevis tendon of the right elbow with anterior capsule release on 04/30/12. Physical examination on 08/09/12 to the left elbow revealed flexion 130 degrees with a 20 degree extension lag. The patient was recommended to continue with physical therapy. Occupational therapy evaluation dated 08/17/12 stated the patient continued to have complaints of right elbow pain and right upper extremity weakness. Objective measures at this evaluation revealed an extension lag in the right elbow to 35 degrees with active flexion to 130 degrees. There was significant loss of grip strength and pinch strength in the right upper extremity when compared to the left. Patient was recommended to continue with

physical therapy. The request for additional physical therapy three times a week for four weeks was denied by utilization review on 08/23/12 as there was no indication that the patient had made reasonable progress with physical therapy or that the patient could not continue with an independent home exercise program. The request was again denied by utilization review on 09/04/12 as there appeared to have been a plateau with physical therapy services.

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

The request for additional physical therapy three times a week for four weeks for the right elbow would not be recommended as medically necessary based on the clinical documentation provided for review and current evidence based guidelines. To date the patient has completed an indeterminate amount of physical therapy based on the most recent therapy update dated 08/17/12. Although the patient continued to have functional limitations on extension of the right elbow and loss of grip strength in the right upper extremity, there is no indication from the occupational physical therapy notes that the patient made any reasonable improvements with physical therapy to date. Current evidence based guidelines do not recommend continuation of physical therapy when there is inadequate documentation regarding the benefits of physical therapy. Given the lack of any clinical documentation supporting progression with physical therapy additional physical therapy would not be supported. As such medical necessity is not established and the prior denials are upheld.

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)