

**P-IRO Inc.**

**An Independent Review Organization**

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**Review Outcome:**

**A description of the qualifications for each physician or other health care provider who reviewed the decision:**

Orthopedic Surgery

**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)

**Description of the service or services in dispute:**

8 additional visits of physical therapy 2 X per week X 4 weeks for the right wrist and elbow

**Patient Clinical History (Summary)**

The patient is a female whose date of injury is xx/xx/xx. The patient noticed right wrist pain. Per note dated 09/24/14, this pain improved after surgery in 2013 where she underwent ulnar nerve release and carpal tunnel release. The pain has come back in the last three months. There is no interval history of trauma to the wrist or elbow. She has had no recent therapy or injections. Three views of the right wrist dated 09/24/14 show no evidence of fracture or arthritis. Three views of the right elbow dated 09/24/14 show no evidence of fracture, arthritis or loose body. On physical examination the right upper extremity has normal alignment and coordination. Sensation is intact. Biceps and triceps strength is 5/5. Deep tendon reflexes are 2+ at biceps and triceps. There is no tenderness to palpation about the wrist and no swelling. Wrist range of motion reveals she can volar flex 90 and dorsiflex 60 degrees. Watson and Finkelstein are negative. Assessment notes right elbow sprain and right hand pain. Physical therapy initial examination dated 10/03/14 indicates she uses a computer 8 hours a day. Elbow range of motion is within functional limits. Right grip is 10#, 20#; left grip 40#, 40#.

Initial request for 8 additional visits of physical therapy 2 x per week x 4 weeks for the right wrist and elbow was non-certified on 10/08/14 noting that the claimant had unknown prior sessions of PT and should be progressed to an independent home exercise program focusing on stretching/strengthening and use of hot/cold packs for pain/spasms. There is no indication of a complication to recovery, comorbidity or extenuating clinical circumstance that would support the frequency/duration and modalities of physical therapy beyond the possibly exceeded guidelines. The denial was upheld on appeal dated 10/21/14 noting that there is no physician evaluation that discusses symptoms, including a physical examination or lists a diagnosis.

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***Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.***

The patient sustained injuries in xx/xxxx. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The number of physical therapy visits completed to date and the patient's objective functional response to prior physical therapy is not documented to establish efficacy of treatment and support additional sessions. The patient's compliance with an active home exercise program is not documented. Therefore, medical necessity is not established in accordance with the Official Disability Guidelines. As such, it is the opinion of the reviewer that the request for 8 additional visits of physical therapy 2 x per week x 4 weeks for the right wrist and elbow is not recommended as medically necessary.

***A description and the source of the screening criteria or other clinical basis used to make the decision:***

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and 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)