

Clear Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Dec/11/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: post op PT RT elbow

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic 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 medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that the request for post op PT right elbow is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 11/12/13, 11/18/13

Follow up note dated 11/04/13, 02/28/13, 03/11/13, 03/25/13, 04/15/13, 05/06/13, 06/03/13, 07/15/13, 08/05/13, 10/07/13

Operative report dated 03/06/13

Surgery orders dated 11/05/13

Letter dated 11/20/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. The patient tripped down some stairs, striking his right upper extremity and his left knee. X-rays of the right elbow revealed a fracture dislocation of his right elbow which was subsequently reduced under sedation. The patient underwent ORIF right radial head fracture and repair of right elbow lateral ulnar collateral ligament with local tissue on 03/06/13. Note dated 05/06/13 indicates that he is just starting on physical therapy and has really only done it for about a week. His pain is improving, but he is still not quite where he wants to be in regards to his motion. Note dated 06/03/13 indicates that he has gotten quite stiff and was recommended to try static progressive splinting. Per note dated 08/05/13, right elbow range of motion has not changed much. He continues to have flexion extension arc from about 35 to 40 degrees to about 85 to 90 degrees. He has about 45 degrees of supination and about 30 degrees of pronation. He is neurovascularly intact in the right upper extremity. Note dated 10/07/13 indicates that the patient reports things have been getting a little bit better. Range of motion is somewhat improved. He gets from about 35 degrees to about 100 degrees. He has about 75 degrees of supination and about 70 degrees of pronation. Per note dated 11/04/13, his flexion-extension arc is from about 45 to 100 degrees. He has about 60 degrees of pronation as well as 60 degrees of supination. Sensation is grossly intact. He does have a positive Tinel's sign at the elbow at the cubital tunnel. He does also report a little bit of numbness and tingling in the ulnar nerve distribution.

Initial request for post op PT right elbow was non-certified on 11/12/13 noting that the request for postoperative physical therapy is not applicable due to the procedure not being medically necessary at this time. The denial was upheld on appeal dated 11/18/13 noting that a concurrent request for right elbow contracture release/ulnar nerve transposition was non-certified, and therefore postoperative physical therapy is not medically necessary.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient underwent ORIF right radial head fracture and repair of right elbow lateral ulnar collateral ligament with local tissue on 03/06/13 followed by a course of postoperative physical therapy. The patient has subsequently been recommended to undergo right elbow contracture release/ulnar nerve transposition. The requested surgical intervention has not been certified. Given that surgery has not been certified, the request for postoperative physical therapy is not supported. As such, it is the opinion of the reviewer that the request for post op PT right 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 & 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)