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**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** June 10, 2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Physical therapy at the frequency of three (3) times per week for two (2) weeks.

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

M.D., Board Certified in Physical Medicine and Rehabilitation.

**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)

The requested physical therapy at the frequency of three (3) times per week for two (2) weeks is not medically necessary.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who reported a work-related injury on xx/xx/xx. The patient reports left elbow pain. The patient is status post open release and repair of the left lateral extensor tendon for epicondylitis with debridement of soft tissue on 1/13/15. In a postoperative evaluation note dated 1/15/15, the patient presented with persistent pain, spasm, and insomnia secondary to pain. Left elbow range of motion remained the same. There was tenderness reported along the lateral epicondyle. Her muscle testing remained weak and supination and pronation were also weak. X-rays were negative for a fracture or dislocation. The patient was advised to continue with

postoperative physical therapy. The progress note dated 5/6/15 notes the patient presented for a follow-up evaluation with complaints of 5/10 pain. The patient noted an overall decrease in symptoms with an increase in range of motion. Upon examination of the left elbow, range of motion had increased, tenderness remained the same, and muscle testing on arm extension remained weak. Supination and pronation had increased. X-rays were negative for a fracture or dislocation. The provider recommended continuing physical therapy treatment for the left elbow.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. The denial letter dated 5/13/15 indicates that the enrollee has attended 30 sessions of physical therapy between the preoperative and postoperative timeframe and there are no barriers to home exercise identified.

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

Per Official Disability Guidelines (ODG), the recommended amount of physical medicine treatment should be an option when there is evidence of a musculoskeletal or neurologic condition that is associated with functional limitations. ODG guidelines indicate that patients should be formally assessed after a six-visit clinical trial to determine whether further treatment is necessary. Per ODG guidelines postsurgical treatment for lateral epicondylitis includes 12 visits over 12 weeks. In this case, the patient is status post open release and repair of the left lateral extensor tendon for epicondylitis with debridement of soft tissue on 1/13/15. The patient has completed 18 sessions of postoperative physical therapy for the left elbow. The amount of completed sessions exceeds ODG guideline recommendations. An additional six sessions would further exceed recommendations. In addition, there is a lack of documentation demonstrating significant functional improvement or exceptional factors to support the medical necessity for additional physical therapy. For the reasons provided, the medical necessity for the requested services has not been established. In accordance with the above, I have determined that the requested physical therapy at the frequency of three (3) times per week for two (2) weeks is not medically necessary for treatment of the patient's medical condition.

**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 JUDGMENT, 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)