

Becket Systems

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/25/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 sessions of PT left shoulder to include: 97110, G0283 and 97140

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

M.D., Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines

03/28/09 Peer Review Dr.

07/17/09 Peer Review Dr.

09/11/09 Peer Review Dr.

12/10/09 Prescription PT

12/14/09 Initial Physical Therapy Evaluation

12/14/09 Peer Review Dr.

12/21/09 Peer Review Dr.

Letter from LM (carrier) --- Non-Certification Decision: 12/15/09; 12/21/09 & 12/23/09

PATIENT CLINICAL HISTORY SUMMARY

This right hand dominant male sustained a lifting/carrying type injury on xx/xx/xx and underwent a C5 to C7 fusion in 12/08 and a left shoulder arthroscopy, acromioplasty with shaving of the glenoid labrum on 12/02/09. The initial physical therapy evaluation for the left shoulder completed on 12/14/09 revealed subjective and objective findings of restricted and painful range of motion along with decreased strength and functional ability. Authorization was requested for 12 physical therapy sessions for the left shoulder to include therapeutic

exercises, manual therapy and E-stim.

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

This review is for 12 physical therapy sessions to the left shoulder. The patient underwent a left shoulder arthroscopy and subacromial decompression approximately 6 weeks ago on 12/02/09. Therapy was initiated on 12/14/09. ODG Guidelines typically recommend up to 24 visits after an arthroscopic subacromial decompression. This request is for 12 sessions and is therefore appropriate and necessary. The reviewer finds that medical necessity exists for 12 sessions of PT left shoulder to include: 97110, G0283 and 97140.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates:
Shoulder – Physical therapy

ODG Physical Therapy Guidelines: Allow for fading of treatment frequency plus active self-directed home PT.

- Rotator cuff syndrome/Impingement syndrome: Post-surgical treatment, arthroscopic: 24 visits over 14 weeks

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)