

Becket Systems

An Independent Review Organization
815-A Brazos St #499
Austin, TX 78701
Phone: (512) 553-0360
Fax: (207) 470-1075
Email: manager@becketystems.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: May/31/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

10 Sessions (5 times a week for 2 weeks) Work Conditioning Program (3 hrs a day)

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

MD, Board certified in Physical Medicine and Rehabilitation with expertise in pain management, wound management and geriatrics. Medical Director of 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG, Forearm, Wrist & Hand
Carrier 3/28/11, 4/25/11
M.D. 4/23/10 to 4/25/11
Provider. 12/9/10
Provider 6/14/10 to 11/30/10
Provider 6/7/10 to 12/2/10
Provider 3/1/10
Clinic 12/22/09
Designated Doctor Exam 4/28/11
Clinic 5/11/10 to 4/29/11
Clinic 11/24/10 to 2/24/11
M.D. 4/16/10
Clinic 12/22/09
M.D. Progress Note 8/3/10 to 4/18/11

PATIENT CLINICAL HISTORY SUMMARY

This claimant has a date of birth of XX/XX/XX. She is X'XX" and XXX pounds. She worked for XX years as a worker in her occupation. She has a history of Right wrist surgery and Right shoulder surgery in 2005. She reported an injury to the left upper extremity XX/XX/XXXX. She was moving 25 pound bowls of objects and felt pain in the hand. She was found to have a left hand sprain, left wrist TFCC tear, left thumb trigger finger and carpal tunnel syndrome on the left. She has had two surgeries to the left wrist on 6/24/2010 and 12/9/2010. She has had therapies. She has hypertension, hypercholesterolemia and cardiomyopathy.

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

Work conditioning is recommended as an option depending on the availability of quality

programs. A screening evaluation should be performed first including the description of injury and previous injuries and work status and availability of job to which to return. There should be a determination of the safety issues and accommodation at the place of work injury. In this instance, the claimant has had an upper extremity injury to the left, which is consistent with a repetitive injury. She has previously had an injury to the right wrist and right shoulder. It is not clear from these notes that therapy has been beneficial for the left upper extremity pain.

It does not appear that prior to beginning the proposed work conditioning, that the patient's work site has been evaluated. Additionally there is no peer-reviewed literature that references work conditioning for this type of injury. Per the ODG p. 148 for carpal tunnel, there is limited evidence demonstrating effectiveness of OT for CTS. Also, the patient has had therapy and there is not evidence of improvement. The ODG does not reference work conditioning for this condition. Based on ODG and the lack of peer reviewed literature that references work conditioning for this patient's condition, the reviewer finds there is not a medical necessity for 10 Sessions (5 times a week for 2 weeks) Work Conditioning Program (3 hrs a day).

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)