Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jun/07/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Physical Therapy Cervical and Left Hip x12

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified Physical Medicine & Rehabilitation and Pain Management

REVIEW OUTCOME:
Upon independent review, the reviewer fins that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Official Disability Guidelines
utilization review determinations 05/03/11, 05/16/11
Physical therapy prescription 05/06/11, 04/15/11
Office visit note 03/31/11
Letter 04/15/11
Treatment and disability information 03/30/11

PATIENT CLINICAL HISTORY SUMMARY
The patient is a male whose date of injury is xx/xx/xx. Workers compensation note dated 03/30/11 indicates that the patient presents with complaints of neck and left hip discomfort. The patient tried applying Flector patches to the affected areas with minimal relief. On physical examination there is mild to moderate tenderness to palpation to the paracervical muscles as well as the trapezius muscles. Spurling's test is negative. Strength and range of motion in the upper extremities are intact. There is tenderness to palpation to the left hip along the superior and posterior aspects of the greater trochanter. Diagnoses are listed as cervical myofascial spasms/strain and gluteal tendinosis.

Initial request for physical therapy was non-certified on 05/03/11noting there is no documentation of recent re-injury or other extenuating circumstances that would support the necessity for additional therapy at this stage of care. There is no information available regarding quantified measures of reasonable improvement associated with previous attendance at skilled therapy. There is no evidence of recent objective findings on examination that would prevent compliance with a home exercise program. The denial was upheld on appeal dated 05/16/11 noting that it is unclear why physical therapy is being requested at this time as opposed to a home exercise program. It is unclear how many sessions of physical therapy the patient has completed to date. The patient is already well

past the acute stage of injury and formal physical therapy treatment at this point may not be of much added functional benefit compared to the patient's daily home exercise program.

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

The patient sustained injuries; however, there is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. It is unclear how many sessions of physical therapy the patient has completed to date, and the patient's objective, functional response to this treatment is not documented. There are no specific, time-limited treatment goals provided. The patient's compliance with an independent, self-directed home exercise program is not documented. The reviewer finds no medical necessity for Physical Therapy Cervical and Left Hip x12.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)