

Becket Systems

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/30/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

(28747) physical therapy three times week times four weeks

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

M.D., Board Certified 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines

Utilization review determinations, Review Med, 10/14/11, 10/27/11

PT status notes, 10/06/11, 09/01/11, 08/19/11, 06/30/11

Physical therapy treatment/progress notes, 10/07/11, 10/10/11, 09/30/11, 10/05/11, 09/26/11, 09/28/11, 09/21/11, 09/23/11, 09/16/11, 09/20/11, 09/09/11, 09/12/11, 09/14/11, 09/06/11, 09/07/11, 08/31/11, 09/01/11, 09/02/11, 08/29/11, 08/30/11, 08/24/11, 08/25/11, 08/26/11, 08/22/11, 08/23/11, 08/16/11, 08/17/11, 08/19/11, 08/10/11, 08/11/11, 08/12/11, 08/15/11, 06/16/11, 06/10/11, 06/13/11, 06/06/11, 06/08/11, 05/31/11, 06/02/11, 05/23/11, 05/25/11, 05/26/11, 05/17/11, 05/19/11, 05/03/11, 05/05/11, 05/11/11, 04/25/11, 04/27/11, 04/29/11, 04/19/11, 04/20/11, 04/14/11, 04/18/11, 04/12/11, 04/13/11, 04/06/11, 04/07/11, 03/30/11, 04/04/11, 03/24/11, 03/28/11, 03/17/11, 03/21/11, 03/22/11, 03/14/11, 03/15/11, 03/01/11, 03/10/11

Update/discharge shoulder extremity, 05/11/11, 04/20/11, 03/24/11

Shoulder evaluations, 08/10/11, 03/01/11

Office visit notes, 11/15/11, 10/18/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female injured onxx/xx/xx when she sustained a comminuted humeral head fracture with 3 pieces. She underwent ORIF left humeral fracture on 01/21/11 and while recovering from surgery began to have adhesive capsulitis. According to the records submitted for review, this patient has completed at least 69 physical therapy sessions to date. PT status note dated 10/06/11 states that the patient complains of fluctuating pain in the biceps tendon, which sometimes limits elevation. Active range of motion is flexion 140, scaption 126, IR 55, ER 65. Strength is rated as 4-/5 in flexion and abduction, 4+/5 internal and external rotation and 5/5 biceps. Office visit note from 11/15/11 states that range of motion is forward elevation 150, external rotation to about 60 degrees and internal rotation is

to L2. The patient still feels some crepitus in the shoulder joint and occasionally with pain.

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

This woman underwent ORIF left humerus on 01/21/11 and appears to have completed at least 69 postoperative physical therapy visits. Therapy completed to date exceeds the Official Disability Guidelines recommendations, and there is no clear rationale provided to support continuing to exceed this recommendation. There are no exceptional factors of delayed recovery documented. As per the ODG, this patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program. The reviewer finds no medical necessity for (28747) physical therapy three times week times four 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)