

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/19/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: CPM x 80 hours

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of this reviewer that CPM x 80 hours has not been established as medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Chiropractic therapy notes 01/29/13-03/27/13
Chronic pain management daily activity sheets 05/03/13-05/21/13
Functional capacity evaluation 04/15/13
Behavioral evaluation 04/16/13
Pre-authorization request 04/23/13
Clinical record 05/06/13
Progress summary 05/18/13
Request for reconsideration 05/30/13
Initial request 06/14/13
Request for reconsideration 06/25/13
Physical therapy evaluation 07/15/13
Appeal letter 07/29/13
Prior reviews 06/18/13 and 06/28/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who sustained an injury on xx/xx/xx. The patient had prior surgical intervention to the right third finger and to date completed 80 hours of chronic pain management program in 05/13. The progress summary report dated 05/18/13 reported a minimal improvement in BDI scores from 13 to 10. BAI score was reduced from 32 to 26. The patient had an increased amount of pain from 5 to 6. The patient was felt not to have plateaued with chronic pain management program and was recommended for an additional 80 sessions. The physical therapy evaluation dated 07/15/13 showed tenderness to palpation of the right third metacarpal. Range of motion showed full extension of the third finger with good flexion. The patient was recommended for additional therapy to address range of motion and strength. The requested 80 additional sessions of a chronic pain management program were denied by utilization review on 06/18/13 as the

patient was not utilizing narcotics and only had occasional use of tramadol. The patient was felt to be able to transition to a home exercise program. The request was again denied by utilization review on 06/20/13 as a recent physical examination was not detailed and there were no imaging studies specified within the records.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for ongoing complaints of right hand pain and has completed the first part of a chronic pain management program. Per the progress summary on 05/18/13 the patient had made improvements with BAI scores but reported increased pain. Recent fear avoidance scores were not provided and there was also no documentation regarding repeat functional capacity evaluation showing whether the patient had improved her overall functional capacity in returning to work. Furthermore there were no physical examination findings in the reconsideration reports showing ongoing exceptional factors for the patient both functionally and from a pain management perspective that would reasonably support an additional 80 hours of a chronic pain management program. There was a physical therapy reevaluation on 07/15/13 which showed full extension of the third finger with good range of motion on flexion. The strength measurement was for the left and there were no right sided strength findings to support ongoing use of a chronic pain management program. As such, it is the opinion of this reviewer that CPM x 80 hours has not been established as medically necessary for this patient based on guideline recommendations indicating that there should be objective findings for persistent functional deficits requiring additional therapy along with evidence of functional improvement with the program to date.

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)