

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/31/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: physical therapy 3 x a week x 4 weeks

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Orthopedic Surgery

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 the reviewer that the request for physical therapy 3 x a week x 4 weeks is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 06/06/13, 06/24/13
Call information dated 06/05/13
Office note dated 06/03/13, 06/12/13
Progress note dated 06/03/13
Peer review letter dated 05/28/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. On this date the patient slipped when stepping up onto a truck and he caught himself with his right arm. The patient was seen and diagnosed with a right shoulder strain. Treatment to date includes diagnostic testing and physical therapy. Diagnosis is listed as sprain of the right shoulder and central disc extrusion at C6-7. Per peer review dated 05/28/13, the last note provided to the peer reviewer was a release which certainly seemed to suggest that the claimant had reached a stable state and did not require any active treatment. It is opined that the patient reached MMI as of 04/29/13. No additional treatment of any type would be considered reasonable and necessary under ODG. Note dated 06/03/13 indicates that the patient returned to work and his right shoulder and neck pain have returned. Office note dated 06/12/13 indicates that the patient has completed 22 physical therapy visits to date. On physical examination motor strength, sensation and reflexes are normal in the upper and lower extremities. The patient has tenderness to palpation in the cervical spine.

Initial request for physical therapy 3 x a week x 4 weeks was non-certified on 06/06/13 noting that the patient has completed 22 physical therapy visits to date and the requested additional 12 sessions exceed guideline recommendations. The clinical notes reviewed do not indicate objective findings as to the progress of the patient's physical therapy program. There is no

indication that the patient has been instructed on or is participating in a home exercise program. The denial was upheld on appeal dated 06/24/13 noting that additional physical therapy is not medically necessary after the completion of 22 visits to date and no documentation of objective progression with that treatment or of instruction in a home exercise program.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has completed 22 physical therapy visits to date. The Official Disability Guidelines support up to 10 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support continuing to exceed this recommendation. There are no exceptional factors of delayed recovery documented. Per peer review dated 05/28/13, the patient reached MMI as of 04/29/13. No additional treatment of any type would be considered reasonable and necessary under ODG. The 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. As such, it is the opinion of the reviewer that the request for physical therapy 3 x a week x 4 weeks is not recommended as medically necessary.

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)