

# Becket Systems

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Aug/03/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** 9 visits of physical therapy (cervical spine)

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

**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 9 visits of physical therapy (cervical spine) is not recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a xx year old whose date of injury is xx/xx/xx. On this date the patient's head hit the door frame of his truck. He was wearing a hard hat. The patient was referred to physical therapy with no relief. The patient did not return to work. He received cervical epidural steroid injections with no significant benefit. Peer review dated 03/09/15 indicates that at this juncture there is nothing else to offer this claimant other than maintenance care for medication management. Office visit note dated 06/24/15 indicates that current problems are myofasciitis/myositis, upper extremity pain, cervical disc without myelopathy, other specified idiopathic peripheral neuropathy, and cervicgia. Current medications are Gabapentin, Norco, alprazolam, metoprolol, metformin, diltiazem, and clonazepam. Chief complaint is neck pain. The note reports that the last physical therapy in 2012 provided no significant benefit. The patient was placed at maximum medical improvement on 02/09/12 and given 15% whole person impairment. On physical examination cervical range of motion is flexion 15, hyperextension 10, bilateral lateral flexion 15 and bilateral lateral rotation 65 degrees. Strength is 5+/5 throughout the bilateral upper extremities. Sensation is intact in the upper extremities. Deep tendon reflexes are normal bilaterally.

Initial request for physical therapy was non-certified on 07/01/15 noting that the patient did not have benefit from prior physical therapy, although the most recent physical therapy was in 2012. It is noted that a 6 visits clinical trial would be supported and within guideline recommendations; however, there was no successful peer to peer and the request could not be modified. The denial was upheld on appeal on 07/10/15 noting that it appears the patient has undergone significant previous physical therapy without benefit. Based on failure of physical therapy, additional physical therapy is not established as medically necessary.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained injuries in xxxx and has undergone prior physical therapy. The submitted records report that previous physical therapy did not provide significant relief. The patient was placed at maximum medical improvement on 02/09/12 and given 15% whole person impairment. Peer review dated 03/09/15 indicates that at this juncture there is nothing else to offer this claimant other than maintenance care for medication management. There is no clear rationale provided to support additional physical therapy when prior physical therapy has not been beneficial for this patient. Therefore, medical necessity is not established in accordance with the Official Disability Guidelines. As such, it is the opinion of the reviewer that the request for 9 visits of physical therapy (cervical spine) is not recommended as medically necessary and the prior denials are upheld.

**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)