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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Feb/10/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 12 sessions of occupational therapy for the left wrist

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 12 sessions of occupational therapy for the left wrist is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. On this date pulled on her wrist. She subsequently underwent left wrist arthroscopy with debridement of synovitis and thermal ablation on 04/24/14 and then was immobilized. Initial evaluation dated 06/12/14 indicates that the patient complains of left wrist pain and stiffness. On physical examination left wrist range of motion is extension 60, ulnar deviation 20 and radial deviation 25 degrees. Re-evaluation dated 08/11/14 indicates that left wrist range of motion is flexion 75, extension 72, ulnar and radial deviation 25 degrees. Strength is rated as 4+/5. Orthopedic follow up note dated 09/15/14 indicates that surgical intervention gave her minimal relief. She continues in occupational therapy which has also given her minimal relief. Re-evaluation dated 11/03/14 indicates that left wrist range of motion is flexion 77, extension 69, ulnar deviation 25 and radial deviation 30 degrees. Strength is 4+/5.

Initial request for 12 sessions of occupational therapy for the left wrist was non-certified on 11/10/14 noting that the Official Disability Guidelines would support an expectation for an ability to perform a proper non-supervised rehabilitation regimen for the described medical situation when an individual is this far removed from undergoing surgical intervention to the affected wrist when past treatment has included access to treatment in the form of supervised rehabilitation services. The denial was upheld on appeal dated 12/29/14 noting that prior treatment included occupational therapy with minimal relief and helped improve the strength as well as tolerance. This injury is nearly one year old. There has been adequate treatment to this point. There has been an arthroscopic procedure which failed to give relief. More occupational therapy will not improve this situation. The distal radial ulnar joint is stable according to the notes.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient underwent left wrist arthroscopy with debridement of synovitis and thermal ablation on 04/24/14 and has completed at least 17 postoperative occupational therapy visits to date. The Official Disability Guidelines support up to 16 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. Note dated 09/15/14 indicates that occupational therapy has given her minimal relief. 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 12 sessions of occupational therapy for the left wrist 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 KNOWLEDGBASE

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)