

Becket Systems

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Dec/29/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 7 days of continuous cryo unit, 14 days of shoulder CPM, 1 CPM soft good

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., 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 this reviewer that the request is partially medically necessary for the seven day rental of a cryo continuous cryotherapy unit only. The denials remains upheld for the requested 14 day rental of a shoulder CPM unit with associated soft goods.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who sustained an injury on xx/xx/xx and was followed for chronic pain in the left shoulder. The patient was being followed and was recommended for open rotator cuff repair for a full thickness rotator cuff tear that was evident on imaging studies. The patient was recommended for post-operative use of a continuous cryotherapy unit and CPM unit for 14 days. Surgical procedures were approved on 08/29/14 by utilization review. In regards to the requested post-operative DME that were denied on 11/26/14 and 12/05/14 as the CPM unit was not recommended by guidelines and no phone call contact was made in order to offer a modification of the request.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient was recommended for open rotator cuff repair to address recurrent rotator cuff tear as evident on imaging studies of the left shoulder. Per current evidence based guidelines the use of continuous cryotherapy units post-operatively is recommended for the shoulder up to seven days in the perioperative period to reduce swelling inflammation and pain. Given the open procedures planned continuous cryotherapy unit would be medically appropriate and reasonable for guidelines. Given the absence of any evidence regarding adhesive capsulitis and other support for post-operative use of a CPM machine the requested 14 day rental of CPM unit with associated soft goods would not be supported as medically appropriate. Therefore it is the opinion of this reviewer that the request is partially medically necessary for the seven day rental of a cryo continuous cryotherapy unit only. The denials remains upheld for the requested 14 day rental of a shoulder CPM unit with associated soft goods.

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)