

# Becket Systems

An Independent Review Organization

815-A Brazos St #499

Austin, TX 78701

Phone: (512) 553-0360

Fax: (207) 470-1075

Email: [manager@becketystems.com](mailto:manager@becketystems.com)

**DATE NOTICE SENT TO ALL PARTIES:** May/26/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** PT 3xWk x 3Wks, right wrist/hand

**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 this reviewer that the request for PT 3xWk x 3Wks, right wrist/hand is not recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who reported multiple injuries after a fall from a ladder measuring 16 feet. The injuries were primarily on the right and included a hip socket fracture, a broken arm, 5 broken ribs, and an L3 fracture. The therapy note dated 12/16/14 indicates the patient having undergone a surgery at the L3 level as well as a surgical intervention to address a pelvic fracture. The therapy notes dated 12/22/14 – 01/21/15 indicate the patient complaining of shoulder stiffness on the right. The notes indicate the patient having undergone therapeutic interventions for the right shoulder. The therapy note dated 03/24/15 indicates the patient complaining of right wrist pain. The note indicates the patient able to demonstrate 16 degrees of right wrist flexion, 29 degrees of extension, 54 degrees of supination, 38 degrees of pronation, along with 4 degrees of ulnar deviation and 5 degrees of radial deviation. Grip strength deficits were identified on the right. The note indicates the patient having initiated physical therapy to address the right wrist complaints. The clinical note dated 03/10/15 indicates the patient having undergone a distal radius fracture procedure. The note indicates the fracture had healed. The note also indicates the patient having initiated physical therapy with a focus on strengthening the musculature. The note indicates the patient able to demonstrate the ability to make a full fist. No sensation deficits were identified. The clinical note dated 03/31/15 indicates the patient being recommended for therapy at the right hand and wrist.

The utilization reviews dated 03/26/15 and 04/16/15 indicate the request for additional physical therapy was not indicated as no exceptional factors were identified in the clinical notes.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The documentation indicates the patient having sustained several injuries after a fall from a ladder, most notably at the right wrist. There is an indication the patient had undergone a total of 24 physical therapy sessions to date in addressing the right wrist and hand complaints following a surgical intervention. There is an indication the patient is continuing with grip strength deficits on the right. There

was also an indication the patient had range of motion deficits on the right. However, given the completion of a full course of physical therapy, it would be reasonable for the patient to progress to a home exercise program to address any residual functional deficits. Additionally, additional therapy is indicated for patients with ongoing exceptional factors. Given the range of motion deficits as well as the strength deficits identified in the clinical notes, it does not appear that any exceptional factors are evident. Given this, the request is not indicated. As such, it is the opinion of this reviewer that the request for PT 3xWk x 3Wks, right wrist/hand 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)