

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

DATE NOTICE SENT TO ALL PARTIES: Apr/12/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Work hardening program 40 hours

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O. - Board Certified Physical 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 this reviewer that the request for work hardening program 40 hours is not medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female. On XX/XX/XX, the patient was seen for initial evaluation in therapy for diagnoses of knee contusion, knee sprain and internal derangement. On XX/XX/XX, the patient was seen in clinic. She complained of bilateral knee pain. She had undergone 8 visits of physical therapy and was taking Naprosyn. On exam, the right knee was tender over the patellar tendon and patellar grind test was positive on the right. McMurray's test was negative on the right knee. The left knee was tender over the medial joint line and patellar tendon, with patellar grind test positive on the left. There was some minor restricted extension of the knee on the left and minor restricted flexion of the left knee. On XX/XX/XX, a Functional Capacity Evaluation was performed noting the patient was currently performing at a sedentary to light PDL and her job required a heavy PDL.

On XX/XX/XX, a Work Capacity Evaluation was performed showing the patient was performing at a light to medium PDL and her job required a heavy PDL. On XX/XX/XX, the patient was seen for Impairment Rating Evaluation, and it was noted that patient was clinically at MMI as of XX/XX/XX, and the patient had completed 160 hours of work hardening and was to return to work with restrictions on XX/XX/XX by the treating physician. No further treatment was recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On XX/XX/XX, a utilization review report stated that the request for 40 hours of work hardening was non-certified but the patient had already undergone 160 hours of work hardening and findings were still in light to medium physical demand level. Current guidelines do not support more than 160 hours of work hardening and there are no extenuating circumstances to support exceeding the guideline recommendations. Therefore, the request is non-certified.

The guidelines state the entirety of the program should not exceed 20 full day visits over 4

weeks or no more than 160 hours. The guidelines also state that neither re-enrollment nor repetition of the same or similar rehab program would be medically warranted for the same condition or injury.

It is the opinion of this reviewer that the request for work hardening program 40 hours is not medically necessary and the prior denial is 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)