Becket Systems

An Independent Review Organization
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Description of the service or services in dispute:

XX visits of physical therapy in the form of extensive passive treatment for the XXXX knee
XX – Therapeutic exercises and treatment for strength and movement recovery
XX – Manual therapy techniques, each 15 minutes, requiring direct contact with physician or therapist
XX – Re-learning XX movement
XX – Therapeutic activities that involve working directly with the provider
XX– XX training therapy
XX – XX-XX management training

Description of the qualifications for each physician or other health care provider who reviewed the decision: Board Certified Internal Medicine

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

☐ Overturned (Disagree)
☑ Upheld (Agree)
☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XXXX XXXX was diagnosed with XX XX fracture of the XXXX XX, subsequent encounter for XX fracture with routine healing (XX.XX) and XX XX ligament (XX) injury, XXXX, initial encounter. (XX.XX).

XXXX was seen by XXXX for a follow-up of XX injury. XXXX stated that XXXX was doing well and was out of the XX knee XX at the XX but put it on when XXXX was out and about. XXXX continued to use XX when XXXX was getting around XXXX. XXXX had not released XXXX back to any kind of work. On XX examination, XXXX had a XX XX XX on to approximately XX degrees of flexion on the XXXX leg. XXXX was appropriately positioned and there was no tenderness underneath the XX. XXXX also had XXXX XX with XXXX. The gait around the room with the XX on was appropriate. Gait afterward going down the hall with the XX was also with good form.

XXXX was evaluated by XXXX. XXXX was complaining of some XX knee pain. Overall, XXXX was doing fine at the time. XXXX had not been through much of the strengthening phase of XXXX recovery.

On XXXX, XXXX was evaluated by XXXX. XXXX was doing well at the time except for some minor complaints of knee XX. XXXX reported being compliant with XXXX home exercise program (HEP) and stated "the feel about the same" regarding how hard they were to perform. The pain was located at the XX XX knee and XX knee on the XXXX. XXXX reported increased pain with weight bearing. The pain was XX and sore, rated at XX/10. It was aggravated by various activities including standing, walking, lifting, bending, and stooping. The gait was independent and XXXX decreased stance time noted with unequal step length. XXXX had made good progress towards XXXX goals over XXXX prior XX visits. XXXX demonstrated an improved gait pattern with increased stance time on the XXXX XX XX without the use of XX. XXXX knee range of motion (ROM) had improved to XX-XX degrees with complaints of knee pain with end range movements. XXXX demonstrated improvements in the XXXX knee flexion and extension strength but continued to have decreased motor control of the knee as noted by XX / XX XX of the knee during XX activities. XXXX had mild XX in the XXXX XX extension compared to the XXXX, which was likely due to decreased XX use of the XXXX XX extremity secondary to XXXX knee pain. XXXX progressed to out-of-XX activities including gentle XX movements without complaints of knee pain and would continue to progress as XXXX was able. XXXX current level of impairment was XX.XX% impaired per the XX XX Functional XX (XX) with an updated goal of XX% or less; XXXX functional limitation was mobility. XXXX might continue to benefit from skilled physical therapy XX to XX times per week for XX weeks to increase knee strength and stability.

An x-ray of the XXXX knee dated XXXX revealed large XXXX XX knee joint XX and possible XX versus impaction fracture along the XX XX plateau. An MRI of the XXXX knee dated XXXX demonstrated acute XX central XX plateau fracture involving the XX insertion; the fracture fragment measured XX x XX.XX cm and resulting in XX insufficiency. There was a large knee joint XX and mild XX XX and XX corner XX / XX. No focal medial or lateral meniscus XX; however, the XX XX XX root XX approaches the region of the XX fracture was noted.

The treatment to date included medications (XXXX), a XX XX XX, XX, and physical therapy.

Per a utilization review decision letter dated XXXX, the requested service of XX visits of physical therapy dated XXXX was not medically necessary. However, XX sessions of physical therapy (PT) were medically necessary. The history and documentation supported the modification to XX sessions of PT to encourage functional restoration as per the Officially Disability Guidelines (ODG). There was no evidence of outlier status. The medical necessity of the additional visits without an interim re-evaluation for progress and status had not clearly been demonstrated.

Per a utilization review decision letter dated XXXX the requested services of physical therapy dated XXXX were denied by XXXX. Rationale: "The documentation provided indicates that the

injured worker has ongoing XXXX XX pain, decreased range of motion, decreased strength, and abnormal gait currently utilizing a XX knee XX and XX secondary to a XXXX knee XX XX fracture and XX XX ligament (XX) injury. The provider requests XX additional physical therapy visits. The injured worker has completed XX visits of physical therapy to date has been approved for XX. The injured worker's current clinical status is unknown as the most recent clinical progress note provided was dated XXXX and most recent physical therapy progress note was dated XXXX. Based on the documentation provided, the medical necessity for an additional XX visits of physical therapy to include therapeutic exercises, manual therapy, XX re-education, therapeutic activities, gait training, and self-care management training, cannot be established as it is unclear at this tune if the injured worker has residual range of motion or strength deficits or still requires an XX XX for XX. Additionally, it was unclear if the injured worker could not be transitioned to a home exercise program at this time. As such, the request is not medically necessary".

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

Based on the clinical information provided, the request for XX visits of physical therapy in the form of extensive passive treatment for the XXXX knee XX – Therapeutic exercises and treatment for strength and movement recovery, XX – Manual therapy techniques, each 15 minutes, requiring direct contact with physician or therapist, XX – Re-learning XX movement,

XX – Therapeutic activities that involve working directly with the provider, XX – Gait training therapy, XX – XX-care management training is not recommended as medically necessary. There is insufficient information to support a change in prior determinations and the previous non-certification is upheld. Additional supervised physical therapy visits would exceed Official Disability Guidelines recommendations. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. 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. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

A description and the source of the screening criteria or other clinical basis used to make the decision:

☐ ACOEM-America College of Occupational and Environmental Medicine

☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
☐ DWC-Division of Workers Compensation
☐ Policies and Guidelines European Guidelines for Management of Chronic Low Back Pain
☐ Interqual Criteria
☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
☐ Mercy Center Consensus Conference Guidelines
☐ Milliman Care Guidelines

- ☐ ODG-Official Disability Guidelines and Treatment Guidelines
- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.