

Becket Systems
Notice of Independent Review Decision
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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH
PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO
REVIEWED THE DECISION: X**

REVIEW OUTCOME:

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

- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

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Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X was driving on X, when X. X injured X neck, left arm, shoulder, and groin where an incision was made. The diagnosis was intervertebral disc disorders with radiculopathy, lumbar region; and postoperative back surgery.

Per the X, physical therapy re-evaluation by X, PT, DPT, X was hypervigilant to pain response, and unmotivated to progress in X per X report. X was status post back surgery on X. At the time, the pain was reported as a dull ache and rated X along the mid-lumbar spine with decreased radiating signs and symptoms. On musculoskeletal examination, lumbosacral flexion active range of motion (AROM) was X, extension X, and side bending was X on the left and right. There was decreased X. Forward head posture and rounded shoulders were seen. X activity limitations included driving, overhead lifting with up to X pounds and lowering to waist level and pushing / pulling with up to X pounds of force. X was unable to participate in regular working duties. X was

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recommended X. On X, X was evaluated by X, PA / X, MD, for follow-up of X neck, back, and arm complaints. At the time, X reported continued pain in the neck, back, and arm, stating X still could not put pressure on the hand and wrist. X had X. X was helping the hips and leg, and a little bit on the back. X stated the overall cervical spine symptoms had decreased and rated the pain level a X. Range of motion of the cervical spine had returned to normal, and there was no radiating pain, numbness and tingling, upper extremity weakness, or headaches reported. X reported occasional stiffness of the neck. X stated that overall, the left shoulder symptoms had decreased and rated the pain X. Range of motion remained the same, there was no numbness and tingling, and upper extremity weakness had decreased. No swelling or bruising was reported. Regarding the left wrist, X stated that overall, the symptoms and pain had decreased and rated it X, with no numbness and tingling, increased grip strength, and no swelling or bruising. X stated the thoracic spine symptoms had been resolved. X stated the lumbar spine symptoms had overall decreased. Pain remained the same. X had back surgery on X. X reported a pain level of X. Range of motion was normal. There was no radiating pain, no numbness and tingling, no lower extremity weakness, no loss of bowel or bladder control, and no saddle anesthesia. Regarding the right inguinal fold (cath site), X stated that overall the symptoms had been resolved. On examination, the left shoulder revealed increased diffuse tenderness. Range of motion had increased; flexion remained the same. Muscle testing showed weak X muscles. Other reported

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findings were of X. Left wrist examination showed X. Tenderness to palpation of the extensor tendons had X. Flexor tendons and cubital tenderness to palpation had X. Extensor pollicis longus and brevis tenderness to palpation had X. Muscle testing grip strength had X. Extension strength had X. Lumbar spine revealed X. The muscle spasm along the paraspinal muscles had X. Tenderness remained the X. Range of motion of the lower extremities revealed X. The diagnosis was cervical disc disorder with radiculopathy, unspecified cervical region; injury of unspecified blood vessel at neck level, subsequent encounter; other specific joint derangements of left shoulder, not elsewhere classified; and intervertebral disc disorders with radiculopathy, lumbar region. X was advised to X. Functional capacity evaluation (FCE) performed on X, noted a X. The plan was to continue X. X was administered intramuscularly. Work status was restricted duty.

Treatment to date included X.

Per a utilization review adverse determination letter dated X and a peer review dated X, by X, DO, the request for X was noncertified as not medically necessary. Rationale: "The claimant has completed a X. The claimant should X. There are no documented extenuating circumstances for this claimant that would warrant exceeding guidelines or going outside of them, therefore the request is non-certified. Therefore, the request for X is not medically necessary."

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A preauthorization request for reconsideration (appeal) letter for X, dated X documented the following: “The medical provider, Dr. X, M.D., has requested this medical treatment because there is an ongoing condition(s) that requires treatment. The X is reasonable and is consistent with the Official Disability Guideline (ODG). The attached medical records supports the efficacy of the X; and establish the clinical indication and necessity of this treatment. Therefore, the X should be determined medically necessary for claimant to reach MMI.”

Per a reconsideration review adverse determination letter dated X, and a peer review dated X, by X, MD, the appeal request for X was denied. The prior denial was upheld with the following rationale: “The request for an X is not medically necessary. The claimant has X. The ODG further stipulates that the frequency of treatment should be tapered or faded over time, so as to facilitate a claimant’s transition to an independent home exercise program. Here, however, the request for X. The claimant’s response to prior care has not, moreover, been favorable. A rather proscriptive X-pound lifting limitation remains in place. The claimant is not working with said limitation in place. The treating provider acknowledged on teleconference that there are no plans of immediately returning the claimant to work. Heavier lifting, carrying, pushing, pulling, standing and walking activities remain problematic. All of the foregoing, taken together, suggests that the claimant has either failed to benefit from or has plateaued

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from a functional perspective with prior care. Additional treatment is unlikely to be beneficial here. Therefore, the request for X is not medically necessary.”

Thoroughly reviewed provided records including provider notes and peer reviews.

While patient may have had limited progress with X. Given still significant progress to be made, X. In addition, request is reasonable and the number of visits in cited guidelines is a suggestion, not a hard and fast rule. X is medically necessary and certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Thoroughly reviewed provided records including provider notes and peer reviews.

While patient may have had limited progress with X. Given still significant progress to be made, X. In addition, request is reasonable and the number of visits in cited guidelines is a suggestion, not a hard and fast rule. X is medically necessary and certified.

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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

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OTHER EVIDENCE BASED, SCIENTIFICALLY VALID,
OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)