

# Becket Systems

An Independent Review Organization  
13492 Research Blvd. Suite 120-262  
Austin, TX 78750-2254  
Phone: (512) 553-0360  
Fax: (207) 470-1075  
Email: manager@becketsystems.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Apr/18/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Work Conditioning Program from 7 am to 11 am for five times a week for two weeks  
97545x10, 97546x20

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

M.D., Board Certified Orthopedic Surgeon

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Official Disability Guidelines

MRI of the Lumbar Spine: 08/19/10

Right L4-5 and L5-S1 transforaminal ESI: 10/11/10, 01/27/11

Dr. OV: 08/09/10, 08/24/10, 11/09/10, 12/02/10 01/25/11, 02/08/11, 02/22/11, 03/22/11

FCE: 02/11/11

Dr., Appeal Letter: 02/22/11

Dr. OV: 12/15/10, 12/28/10, 01/11/11, 01/16/11 03/02/11

Peer Review: 03/11/11, 03/23/11

Lab: 12/17/10

Physical Therapy Notes: 09/07/10, 09/16/10, 09/20/10, 09/21/10, 09/22/10, 09/24/10, 09/27/10, 09/29/10, 10/01/10, 10/04/10, 10/05/10, 10/06/10, 10/13/10, 10/19/10, 10/20/10, 10/22/10, 11/02/10, 11/04/10, 11/08/10, 11/10/10, 11/16/10

Dr. OV: 08/30/10

X-ray of lumbar spine: 08/09/10

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a XX year-old male who sustained a work related injury to his low back on XX/XX/XXXX. He was carrying a heavy object when he stopped suddenly and began to have low back pain. The claimant had physical therapy and two epidural steroid injections. The second injection gave him 100% relief of his pain. He was able to stop his hydrocodone and naproxen after the injection. Dr. recommended a work hardening program, which was noncertified as there was no indication that a multidisciplinary approach to the claimant's

recovery was needed. When the claimant saw Dr. on 03/22/11, he did not think the claimant was a work hardening candidate but rather a candidate for work conditioning. Dr. felt that this was more of a physical process rather than a return to work motivational issue. The work conditioning was noncertified in a peer review dated 03/23/11 as there was no documentation that there was not access to a modified duty return to work program.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

The most recent note in this case would appear to suggest 100 percent pain relief after an injection. Work hardening was previously non-certified, work conditioning was previously non-certified. In this case there have really been no recent findings documented to suggest that further significant treatment is needed. There is no clear-cut documentation of functional deficits. It is unclear what form of traditional physical therapy regimen has been attempted and failed. In short the Official Disability Guidelines are not satisfied for medical necessity regarding the proposed work-conditioning program. The reviewer finds there is not medical necessity for Work Conditioning Program from 7 am to 11 am for five times a week for two weeks 97545x10, 97546x20.

**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)