

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/25/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 Physical Therapy, Lumbar

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

M.D., 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines

Request for IRO dated 11/09/11

Utilization review determination dated 10/24/11

Utilization review determination dated 10/28/11

Clinical records Dr. dated 07/26/11, 08/15/11, 09/01/11, 09/08/11, 10/04/11 and 10/17/11

Physical therapy progress notes, 2011

MRI lumbar spine 10/04/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who is reported to have injured her low back as result of lifting. Per clinic note dated xx/xx/xx she has had therapy for 10 months now. It has helped but she continues to have pain across her low back. Occasionally she feels radiation into left lower extremity. MRI dated 10/06/10 demonstrated circumferential 2-3 mm disc protrusion containing annular tears in left foraminal and anterior central zone. There is mild left sided foraminal stenosis. The inferior margin of the exiting left L3 nerve root is effaced in the left neural foramen. The right neural foramen is patent. The anterior surface of the thecal sac is slightly compressed. There is facet ligamentum flavum hypertrophy bilaterally that mildly compresses the posterior lateral aspect of the thecal sac. The anterior/posterior dimension of canal is 8 mm. There is degenerative disc narrowing with desiccation and anterior spondylosis. At L4-5 there is a broad based posterior 2-3 mm disc protrusion that extends into right neural foramen producing stenosis mildly impinging upon inferior surface of exiting right L4 nerve root. The left neural foramen is patent. The posterior disc margin effaces the thecal sac without compression. There is facet and ligamentum flavum hypertrophy that mildly compresses the posterior or lateral aspect of thecal sac bilaterally. The anterior / posterior dimension of central canal is 11 to 12 mm. There is degenerative disc narrowing and desiccation and anterior spondylosis. The articular facets are slightly asymmetrical in

orientation. At L5-S1 there is broad based 2-3 mm disc protrusion that extends into left neural foramen effacing the inferior surface of exiting left L5 nerve root without compression or displacement. The right neural foramen is patent. The posterior disc protrusion effaces but does not displace descending S1 nerve roots. On physical examination the claimant has no obvious deformities. Straight leg raise is positive on left. Gait is normal. Strength is 5-/5 in EHL and knee extensors. There is decreased sensation on top of left thigh as well as lateral calf. Reflexes are 2+ and symmetric. Left L3 and L5 epidural steroid injections were recommended. She was also referred for physical therapy. A clinic note dated 09/01/11 states the lumbar epidural steroid injection was only 10% effective. She underwent physical therapy evaluation on 09/08/11 and it was recommended she undergo a course of physical therapy 3x4 for total of 12 sessions.

She had a second transforaminal epidural steroid injection, which was only 20% effective. She has completed 4 visits of physical therapy, which are reported to have been effective.

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

The available records indicate the claimant has long standing history of low back with multilevel degenerative disc disease and stenosis at L3-4, L4-5 and L5-S1. She participated in 10 months of physical therapy without apparent benefit given the fact she sought treatment from Dr.. She has undergone at least two epidural steroid injections with little or no response and has continued with additional physical therapy. The records as provided do not clearly elucidate the claimant's response to treatment other than she has had good response. There is no definitive data regarding functional improvements. There is no indication of potential transition to self-directed home exercise program. The previous denials are consistent with ODG guidelines. There is no medical necessity for 12 Physical Therapy, Lumbar.

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)