

Becket Systems

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/17/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy for the lumbar spine and right shoulder - 4 visits

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

M.D., 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines

Utilization review determination dated 10/25/11, 10/18/11

Office visit note dated 10/13/11, 09/30/11, 02/28/11, 02/09/11, 02/11/11, 02/14/11, 02/17/11, 02/18/11, 02/21/11, 02/26/11, 03/02/11, 03/08/11, 03/14/11, 03/16/11, 03/22/11, 04/02/11, 04/29/11, 05/13/11, 05/27/11, 09/08/11, 09/14/11, 09/15/11, 09/19/11, 09/26/11, 10/06/11, 10/10/11

MRI right shoulder dated 10/10/11

MRI lumbar spine dated 10/04/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. He was in the when his partner rear-ended another truck. Diagnoses are listed as lumbar IVD degeneration; lumbar/lumbosacral subluxation; lumbosacral joint sprain/strain and spasm of muscle. Follow up note dated 09/30/11 indicates that the patient's lower back has been hurting more than usual. On physical examination motional palpable fixation, subluxation was found in left L4, right L5, S1, sacrum, shoulder. MRI of the lumbar spine dated 10/04/11 revealed slight disc dehydration at the lower two lumbar levels with marked loss of disc space height at L5-S1; disc protrusion centrally at L5-S1 extending minimally more to the right than left of midline; no obvious mass effect on the S1 nerve roots; no critical central or foraminal stenosis. There is a disc protrusion centrally and extending into the left subarticular recess at L4-5; there is subarticular recess stenosis on the left with potential for mass effect on the traversing left L5 nerve root; there is no critical central spinal stenosis. MRI right shoulder dated 10/10/11 revealed no full thickness rotator cuff tear, minimal distal supraspinatus tendinosis; mild distal subscapularis tendinosis, possibly associated with some low grade partial thickness tearing of the superior fibers; normal cuff musculature; mild AC joint degenerative arthropathy. Physical examination on 10/13/11 noted reflexes are normal and graded equal bilaterally.

Kemp's and Lasegue's are negative. Lumbar range of motion is flexion 55, extension 25, left lateral flexion 20, right lateral flexion 25 and bilateral rotation 40 degrees. Examination of the right shoulder revealed decreased extension, external rotation. Palpation over the rotator cuff tendons revealed tenderness. A request for physical therapy was denied on 10/18/11 noting that ODG recommends 9-10 sessions of physical therapy for the patient's diagnosis. This has been exceeded with initial improvement; however, there has been no further improvement in the last 8 months. There is no evidence of improvement in functional abilities. The denial was upheld on appeal dated 10/25/11.

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

This patient has completed extensive conservative treatment for this injury with initial improvement; however, the patient has not continued to improve with this treatment. The Official Disability Guidelines support 9-10 visits of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. 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. The reviewer finds no medical necessity for Physical therapy for the lumbar spine and right shoulder - 4 visits.

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)