

Becket Systems

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: October/12/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar spine PT of thrice a week for four weeks 97110, 97140, 97116, 97530

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

Workers' Comp Services, 09/01/11, 09/20/11

Notes, 08/26/11, 03/29/10

Office visit notes, 08/19/11, 08/10/11, 01/24/11, 09/28/11, 11/04/10, 09/23/10, 08/27/10, 08/23/10, 06/25/10, 06/16/10, 06/02/10, 05/07/10, 03/30/10, 03/22/10, 02/12/10, 01/25/10, 12/14/09, 11/06/09, 10/29/09, 09/11/09

PT daily progress notes 04/26/10, 04/20/10, 04/08/10, 04/06/10

Reports, 08/19/11, 06/25/10, 03/22/10, 02/12/10, 12/14/09

Operative note, 06/17/10

Designated doctor evaluation, 01/06/10

Myelogram, 08/26/09

MRI lumbar spine, 12/02/08

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xxxx. He slipped on his left leg and landed on his buttocks injuring his low back. MRI of the lumbar spine on 12/02/08 revealed multilevel lumbar spondylitic changes. There is moderate bilateral foraminal narrowing at L4-5 and moderate left foraminal narrowing at L3-4. Designated doctor evaluation on 01/06/10 indicates that the patient has a past surgical history significant for knee surgery. Diagnosis is lumbar disc herniation. The patient was determined to have reached MMI as of 05/01/09 with 5% whole person impairment. Initial evaluation dated 03/29/10 indicates that the patient has undergone some PT in the past with no significant benefits. He had another course of physical therapy in 2010. Follow up note from 05/07/10 indicates that physical therapy has been quite painful for him. The patient underwent left L3-4, right L4-5 transforaminal epidural steroid injection on 06/17/10 with 20% improvement. An evaluation on 08/26/11 indicates that the patient has had some PT in the past with no significant benefit. He is not a surgical candidate at this time. On physical examination lumbar range of motion is limited. Strength is rated as 5/5 in the bilateral lower extremities. Straight leg raising is negative and slump test is positive bilaterally.

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

The reviewer finds there is not a medical necessity for Lumbar spine PT of thrice a week for four weeks 97110, 97140, 97116, 97530. This patient has already completed at least 20 sessions of physical therapy to date "with no significant benefit". Given the lack of efficacy of prior therapy, it is unclear why additional therapy is being requested at this time. On 05/01/09 he was placed at MMI. There are no specific, time-limited treatment goals provided. The requested physical therapy is in excess of Official Disability Guidelines recommendations, and there are no exceptional factors of delayed recovery documented. The patient's compliance with a home exercise program is not documented.

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)