

# Becket Systems

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Aug/02/2012

**IRO CASE #:**

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

18 additional sessions of physical therapy for the lumbar spine

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

M.D., Board Certified Pain Medicine

**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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** The reviewer finds the request for 18 additional sessions of physical therapy for the lumbar spine is not medically necessary.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who injured his low back on xx/xx/xx. He was pulling a wooden pallet from debris when he experienced low back pain radiating to the left lower extremity. He sustained a second injury when he fell off a truck on 09/12/11. He had transforaminal epidural steroid injection on 08/11/11 and was noted to experience approximately 80% relief. MRI of the lumbar spine on 07/20/11 indicated L5-S1 left disc protrusion 6.3mm with facet changes producing severe narrowing of the left canal, recess and foramen which compresses with compression of the left S1 nerve root. MRI of the lumbar spine on 10/03/11 revealed moderate disc degeneration at L5-S1 with a superimposed 3-4mm broad based posterior central left paracentral disc protrusion effacing the anterior thecal sac and the very proximal left S1 root sleeve within the lateral recess. There is moderate bilateral facet degeneration with moderate central stenosis; mild to moderate left foraminal narrowing due to endplate spondylosis and facet arthrosis. Bilateral facet degeneration was noted at L4-5 and L3-4 to a mild extent. At L4-5 there is posterior spondylosis more prominent right posterolaterally and right laterally resulting in mild right foraminal narrowing. There was borderline central canal stenosis at L4-5. Electrodiagnostic testing on 01/19/12 revealed evidence of acute S1 radiculopathy. There also is evidence of a sensory motor peripheral neuropathy likely secondary to the claimant's diabetes and not related to work injury. Per post designated doctor RME examination the claimant exhibited 6/8 positive Waddell's signs significant for symptom magnification. A request for additional physical therapy sessions for the lumbar spine was non-certified per pre-authorization dated 06/06/12 noting that the claimant initially was treated with physical therapy and recently sent to Dr. for consultation. It was noted the claimant had an MRI done in the past but the report was not furnished. The requested physical therapy almost one year post initial date of injury is not reasonable and necessary and not within Official Disability Guidelines standards of care for the diagnosis submitted. No physical examination or history that would outline current subjective complaints or objective clinical findings was provided to support the medical necessity for physical therapy outside

Official Disability Guidelines. A reconsideration request for 18 additional physical therapy visits for the lumbar spine was non-certified per pre-authorization review dated 06/27/12. Claimant was noted to sustain an injury on xx/xx/xx due to lifting a pile of debris. Physical therapy initial evaluation notes dated 05/29/12 documented subjective complaints of severe back pain and left lower extremity radiculopathy. Motor strength was graded in the lumbosacral spine at 1/5 for the anterior/posterior obliques. There was severe posterior muscular guarding in the erector spinae and gluteus medius on the left with moderate guarding in the piriformis right and left and moderate to mild guarding of the erector spinae, gluteus medius and piriformis on the right. Range of motion of the lumbosacral region reported extension was 0%, flexion 20%, right and left rotation 20%, side bending right 20% and side bending left 0%. Reflexes and sensation was noted to be 1+ and diminished in the left Achilles tendon and left lateral hamstring. Straight leg raise on the right and left was 35 70 degrees with bilateral pain noted. Slump testing and AP sharing aggravated symptoms in posterior quadrant inspection showed pain in the lumbosacral area. Physical therapy notes dated 06/22/12 documented after two sessions and three cancelled/missed sessions no changes in subjective/objective findings. It was noted that the claimant was using medications Flexeril and Mobic. MRI was stated to document herniated nucleus pulposus of greater than 6mm at L5-S1. It was noted there was no updated physical examination since physical therapy assessment of 05/29/12 to document ongoing functional and physical deficits. It was noted that previous utilization review recommended non-certification of the request for additional physical therapy as the request was one year post injury and not within standard of care and there was no recent updated on subjective complaints or objective physical examination findings to support the request for physical therapy. Claimant was stated not to be working but has missed or cancelled three sessions of physical therapy from previous nine prescribed sessions. Without documentation of progression from physical therapy or appropriate reasons for not participating in physical therapy, the request for additional physical therapy of 18 sessions of the lumbar spine would not be supported. It was noted that guidelines would support 10 visits of physical therapy over a period of eight weeks for a lumbar sprain strain as well as for medical treatment of intervertebral disc disorder without myelopathy.

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

This claimant was approved for nine visits of physical therapy. He attended only two sessions and missed or cancelled other sessions. There is no explanation in the records provided for this claimant's non-compliance with previous physical therapy. Per post designated doctor RME examination dated 05/21/12 the claimant exhibited 6/8 positive Waddell's signs significant for symptom magnification. There is no current detailed examination documenting motor, sensory or reflex deficits. Per Official Disability Guidelines, up to 10 visits over eight weeks is supported for lumbar sprain strain injury or for intervertebral disc disorder without myelopathy. The request for 18 additional visits exceeds recommended guidelines with no documentation of exceptional factors that would warrant therapy in excess of recommendations of guidelines either in duration or number of visits. Consequently the reviewer finds there is no medical necessity for 18 additional sessions of physical therapy for the lumbar spine.

**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 KNOWLEDGBASE

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)