

# Becket Systems

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jun/08/2012

**IRO CASE #:**

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

Chiropractic manips 98940-1-2 areas, 98943 extra spinal, and 97110 x2ther

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Official Disability Guidelines

Utilization review determination dated 04/06/12, 05/10/12

Preauthorization request dated 01/09/12, 02/17/12

MRI lumbar spine dated 03/15/12

MRI cervical spine dated 03/15/12

Office visit note dated 01/25/12, 01/27/12, 02/02/12, 02/03/12, 02/06/12, 02/07/12, 02/10/12, 02/13/12, 02/16/12, 02/17/12, 02/24/12, 02/28/12, 03/06/12, 03/08/12, 03/15/12, 03/16/12, 03/22/12, 03/27/12, 03/16/10, 03/17/10, 03/26/10, 03/28/10, 04/27/10, 05/06/10, 07/19/10, 03/19/12

Designated doctor evaluation dated 11/18/11

Functional capacity evaluation dated 08/25/10

MRI cervical spine dated 02/08/04, 07/04/04

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xx. He was struck by a bull. His injuries include a scalp laceration, fracture the transverse processes of T8, L1 and L2, and posterior rib fractures of the 9th through 11th ribs on the right side. The patient also has a broken thumb. While in the hospital, the patient had his newly diagnosed hepatic cirrhosis evaluated by the hospitalist service. The patient was discharged to home in good condition within a couple of days. The patient subsequently underwent right thoracoscopy with drainage of delayed hemothorax on 03/29/10. Designated doctor evaluation dated 11/18/11 indicates that the patient underwent left thoracotomy and complete decortications on 01/21/11. Diagnoses are right hemothorax, resolved; cervical strain; multiple contusions, resolved; multiple rib fractures; fracture right proximal phalanx, thumb; transverse process fracture of thoracic and lumbar spine. The patient was determined to have reached MMI as of 09/03/10 with 10% whole person impairment. The patient presented on 01/09/12 with complaints of

constant daily cervical pain and pain that radiates into the right arm as well as daily thoracolumbar discomfort and intermittent radicular pain down the right posterior leg. MRI of the lumbar spine dated 03/15/12 revealed a right far lateral disc protrusion or extrusion t L2-3 which appears to contact the right L2 nerve root as it exits the L2-3 neural foramen. There is mild central canal stenosis at L4-5 secondary to disc bulging and facet arthropathy. The disc bulge may contact the L5 nerve roots within the lateral recesses. There is minimal bilateral foraminal stenosis at L4-5. A disc bulge and annulus fibrosis fissure are noted at L5-S1, right greater than left foraminal stenosis is present. The disc contacts the right L5 nerve root within the neural foramen. MRI of the cervical spine dated 03/15/12 revealed cervical spondylosis resulting in mild central spinal canal stenosis at the C5-6 and C6-7 levels. The most recent note dated 03/27/12 indicates that the patient's neck pain and low back pain have not changed since last visit.

Initial request for chiropractic manipulations was non-certified on 04/06/12 noting that there are no objective measures of functional improvement such as range of motion or strength testing. Dr. reports that he does not have any range of motion measurements, but that he has grossly slight improvement. The patient was assigned a 10 percent impairment and placed at MMI in November 2011. The patient has had a thorough course of PT and chiropractic up to this point and continued treatment exceeds Texas treatment guidelines. The denial was upheld on appeal dated 05/10/12 noting that the 03/27/12 report only noted essentially subjective pain and radicular complaints along with exam findings of spasm and fixations. An updated exam is needed to support medical necessity and appropriateness for some additional treatment. Following 18 prior PT visits and 17 prior chiropractic visits, the patient is still reporting pain at 7-8/10 and has ongoing reported upper and lower extremity radicular symptoms per the 03/27/12 report. This is hardly indicative of a successful treatment history.

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

Treatment to date includes 18 sessions of physical therapy and 17 sessions of chiropractic treatment. There is no comprehensive assessment of the patient's objective, functional response to treatment completed to date submitted for review to establish efficacy of treatment and support additional sessions. There is no current, detailed physical examination submitted for review, and no specific, time-limited treatment goals were provided. The patient's compliance with an active home exercise program is not documented. The ODG criteria is not fulfilled based on the clinical data provided. The reviewer finds that medical necessity does not exist for Chiropractic manipulations 98940-1-2 areas, 98943 extra spinal, and 97110 x2ther.

**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)