

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jun/26/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 12 sessions of additional lumbar physical therapy at 3 times a week for 4 weeks, not to exceed more than 4 units per sessions

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O. 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that the request for 12 sessions of additional lumbar physical therapy at 3 times a week for 4 weeks, not to exceed more than 4 units per sessions is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination 04/09/13, 04/29/13, 05/05/11, 04/13/07, 11/28/12, 10/01/12, 05/09/12, 02/13/12, 02/08/12, 01/06/12, 12/22/11, 05/02/11, 11/04/09, 10/14/09, 08/28/09, 07/22/09, 07/09/09, 10/12/07, 07/31/07, 07/19/07, 01/08/07, 06/29/06, 05/08/06, 03/24/06, 04/15/05, 09/18/08, 09/30/08

Pre-authorization request 04/03/13

Medication management report 02/22/13

Letter of medical necessity 04/09/13, 05/26/09, 10/27/08, 12/07/07

Handwritten physical therapy assessment and plan of care 03/06/13

Orthopedic report 01/04/13, 06/12/12, 04/27/12, 04/18/12, 03/08/12, 02/02/12, 12/09/11, 10/28/11, 09/01/11, 04/21/11, 04/04/11, 03/07/11, 01/04/11, 10/22/10, 07/15/10, 04/16/10, 02/19/10, 01/14/10, 11/17/09, 04/27/09, 01/29/09, 08/29/08, 04/30/08, 01/14/08, 08/04/09, 10/04/07, 07/06/07, 05/09/07, 03/28/07, 02/21/07, 12/15/06, 11/10/06, 03/15/05, 09/22/06, 04/18/06, 03/07/06, 12/08/05, 10/24/05

Follow up note 04/05/13

MRI lumbar 04/13/11 and 12/07/04

Manual muscle strength exam 02/22/13, 01/04/13, 12/13/12, 11/05/12, 06/01/12, 04/18/12, 02/02/12, 12/09/11

Electrodiagnostic report 05/18/11

Left shoulder MR arthrogram 04/13/11 and 09/17/07

Left shoulder arthrogram 03/30/11

MMT/ROM 01/04/11, 10/22/10, 07/15/10, 04/16/10, 08/04/09, 04/27/09, 04/30/08, 09/06/07, 07/06/07, 03/28/07, 02/21/07, 11/10/06, 09/22/06, 04/18/06

Radiographic report 08/04/09, 04/27/09, 01/29/09, 10/17/02, 05/18/02, 03/15/05

Cervical myelogram 06/14/07
MRI cervical spine 03/29/05 and 08/09/02
EMG/NCV 01/19/05, 10/06/04, 09/05/02, 10/16/02
MRI left shoulder 12/07/04 and 03/24/03
Operative report 12/19/12, 10/29/12, 06/01/12, 01/23/12, 05/19/11, 11/11/09, 02/06/07, 10/20/06, 07/19/06, 06/14/06, 06/07/06, 04/19/06, 04/28/05
Telephone conference 07/20/09
Handwritten history/physical 07/06/07
Reference material
IME 02/08/12, 02/16/11, 06/17/09, 02/07/05

Letter 12/10/07, 10/12/07, 08/25/09, 07/28/09, 07/10/07, 07/05/07, 06/13/07, 05/16/07, 05/03/07, 04/28/07, 11/04/06, 04/24/03, 09/12/06, 10/19/05, 08/26/05, 07/29/05
IRO 11/30/07, 08/24/09, 09/06/07
RME 11/19/07
Prospective review 11/05/07
Telephone conference 10/29/07, 10/11/07, 04/12/07
Order of dismissal 09/14/09
Order setting pre-hearing 09/22/09
Progress note 02/18/10
TWCC-69 narrative 09/06/07
Office note 03/30/07, 12/14/04, 12/02/04, 11/11/04, 10/21/04, 09/21/04, 06/22/04, 04/20/04, 02/19/04, 01/20/04, 12/18/03, 11/04/03, 09/25/03, 08/14/03, 06/19/03, 04/24/03, 02/27/03, 01/23/03, 12/12/02, 10/17/02, 09/19/02, 08/22/02, 08/08/02, 07/18/02, 06/20/02, 05/30/02, 04/25/06, 03/29/06, 03/14/06, 03/31/05
Peer review 03/21/05
Neurological examination 01/19/05, 10/31/03
Designated doctor evaluation 03/19/03, 10/17/06, 03/08/06, 11/10/05, 04/27/05
Decision and order 02/15/06

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. The submitted records indicate that the patient sustained a previous injury on xx/xx/xx when she lost control of a police cruiser and it slid into a pole. No dramatic physical findings were noted at that time except for tenderness, impaired mobility and soreness in the chest and rib cage. The patient received treatment consisting of physical therapy, work conditioning, work hardening and medication management. The patient was subsequently involved in a second motor vehicle accident on xx/xx/xx when she was stopped and was rear-ended by another vehicle traveling at approximately 30 mph. The patient underwent an initial course of physical therapy. IME dated 02/07/05 indicates that the patient gave very poor effort and there may be signs of symptom magnification. The patient probably has had a cervical sprain/strain event. EMG/NCV dated 01/19/05 revealed no evidence to suggest lumbosacral radiculopathy. Per peer review dated 03/21/05, complete resolution would have been anticipated in 4-8 weeks. Designated doctor evaluation dated 04/27/05 indicates that expected MMI date is 10/27/05. The patient underwent SNRB at L5-S1 on 04/28/05. Designated doctor evaluation dated 11/10/05 indicates that expected MMI date is 03/10/06. Designated doctor evaluation dated 03/08/06 indicates that anticipated MMI date is 09/08/06. The patient underwent lumbar epidural steroid injection on 04/19/06, 06/07/06, 07/19/06. The patient underwent left shoulder arthroscopy on 06/14/06. Designated doctor evaluation dated 10/17/06 indicates that she reached statutory MMI as of 09/12/06. The patient subsequently underwent cervical epidural steroid injection on 10/20/06 and cervical facet injections on 02/06/07. RME dated 11/19/07 indicates that no further diagnostic testing or treatment is indicated for the cervical and lumbar. IME dated 06/17/09 indicates that she would not need any physical therapy, except postoperatively following any additional shoulder procedure. The patient underwent left shoulder arthroscopy on 11/11/09. IME dated 02/16/11 indicates that the patient has had a change in her physical status without any new intervening injury, and repeat lumbar MRI imaging was recommended. MRI of the lumbar spine dated 04/13/11 revealed the lateral recesses and neural foramina bilaterally at L4-5 are mildly encroached secondary to subtle spondylosis, annular disc bulging, and bilateral ligamentum flavum hypertrophy. The central canal at L4-5 is borderline stenotic. The lateral recesses at L5-S1

are borderline narrowed. No central canal stenosis at L5-S1 is seen. The neural foramina bilaterally at L2-3 and L3-4 are mildly encroached secondary to subtle spondylosis and annular disc bulging. EMG/NCV dated 05/18/11 revealed evidence of mild, chronic right S1 radiculopathy. The patient subsequently underwent lumbar epidural steroid injection on 05/19/11, 01/23/12 with 80% relief. IME dated 02/08/12 indicates that a follow up epidural steroid injection would be appropriate. The patient underwent cervical epidural steroid injection on 06/01/12 with 80% initial relief followed by CESI on 10/29/12 and lumbar epidural steroid injection on 12/19/12. Orthopedic report dated 01/04/13 indicates that the patient noticed significant improvement after the lumbar epidural steroid injection.

Follow up note dated 04/05/13 indicates that lumbar region pain is rated as 5/10. Medications are listed as Ultracet, Feldene, Zanaflex and Lorcet. Indicates physical examination hip flexor strength is rated as 5/5 bilaterally. Patellar reflexes are 2/4 bilaterally. The patient walks with a normal, non-antalgic heel to toe gait. Strength is 5/5 in the bilateral lower extremities. Straight leg raising causes back pain only bilaterally.

Initial request for 12 sessions of additional lumbar physical therapy was non-certified on 04/09/13 noting that claimant has had PT in the past. There is no indication for PT for an incident in 2004. Claimant does not meet ODG recommendations. The denial was upheld on appeal dated 04/29/13 noting that additional records were not provided for review. The claimant has had a prior history of physical therapy with no recent re-injury or trauma supporting the need for further formal physical therapy in excess of the guidelines recommendations versus continuation of a home exercise program.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries in xx, over 8 years ago, and has completed extensive conservative treatment to date including physical therapy, home exercise program and injection therapy. RME dated 11/19/07 indicates that no further diagnostic testing or treatment is indicated for the cervical and lumbar. IME dated 06/17/09 indicates that she would not need any physical therapy, except postoperatively following any additional shoulder procedure. Serial progress notes indicate that the patient is compliant with a home exercise program. There is no clear rationale provided to support additional supervised physical therapy at this time for an injury that occurred over 8 years ago. 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. As such, it is the opinion of the reviewer that the request for 12 sessions of additional lumbar physical therapy at 3 times a week for 4 weeks, not to exceed more than 4 units per sessions is not recommended as medically necessary.

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)