

# Becket Systems

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Feb/25/2009

**IRO CASE #:**

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

Chronic Pain Management Program x 10 Sessions

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

Chiropractor  
AADEP Certified  
Whole Person Certified  
TWCC ADL Doctor  
Certified Electrodiagnostic Practitioner  
Clinical practice 10+ years in Chiropractic WC WH Therapy

**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**

Adverse Determination Letters, 12/9/08, 12/31/08  
ODG Guidelines and Treatment Guidelines  
Associates, 12/1/08, 12/19/08, 10/24/08, 12/18/08  
Back and Neck Clinic, 11/19/08  
FCE, 11/17/08  
Session Note, 2/7/08

**PATIENT CLINICAL HISTORY SUMMARY**

The xx-year-old female was involved in an occupational injury in xx/xx/xx. She was apparently working xxxxxx. Since the injury, she has undergone medication, physical therapy, MRI, EMG, and eventually surgery to the right shoulder on 7-02-2007. She participated in post-op therapy and 6 sessions of individual psychological therapy in early 2008. The records provided for this review did not have a written description of job duties for this person, nor a

description of a job to return to. Ten (10) sessions of chronic pain management program have been requested.

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

This injured employee currently does not meet the ODG guidelines for 10 sessions of chronic pain management as requested. Records do not indicate that she has a job to return to, as there are no written job descriptions or verification of a job from the employer. The records do not indicate that she is currently on any medications. The records do not indicate that she has exhausted a lower level of care. She does not appear to have benefited from the prior 6-sessions of individual psychological therapy in early 2008. The patient does not meet the guidelines for a chronic pain program, and no reason has been given in this case for why the guidelines should not be followed. The reviewer finds that medical necessity does not exist for Chronic Pain Management Program x 10 Sessions.

**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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)