

# Becket Systems

An Independent Review Organization  
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**DATE OF REVIEW:**

Jun/05/2009

**IRO CASE #:**

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

Chronic Pain Management Program 5xwk x 4wks (97799)

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

MD, Board Certified in Physical Medicine and Rehabilitation  
Subspecialty Board Certified in Pain Management

**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**

Determination Letters, 4/17/09, 5/11/09

Clinic of, , MD, Letter to

Fellow Doctors, 5/20/09

Request for Reconsideration, 5/4/09

Preauthorization Request, 4/13/09

M.Ed., 4/7/09, 11/11/08

Dr, MD, 9/30/08

ODG Guidelines and Treatment Guidelines

MRI of Lumbar Spine, 7/3/08

Summit Diagnostics, 8/26/08

Dr. 6/23/08

Dr., MD, 7/3/08

Dr. 7/23/08, 7/25/08

Dr. DC, 8/8/08, 8/18/08, 8/28/08, 9/30/08, 10/17/08, 10/31/08,

11/7/08, 3/23/09, 4/13/09

PA-C, 9/9/08

Dr. 11/12/08

Dr. MD, 1/5/09

Dr. DC, 1/9/09

Work Hardening Program, 12/8/08-3/30/09 (Records from 19 visits)

Physical Therapy, 6/24/08-9/9/08 (9 visits)

Employers First Report of Injury, xx-xx-xx

Work Hardening Discharge Report, 3/30/09

### **PATIENT CLINICAL HISTORY SUMMARY**

This is a man injured on xx-xx-xx. He was originally felt to have a strain. He had ongoing back pain. His work up included an MRI that showed disc protrusion at L3/4, and a protrusion/herniation at L4/5 and L5/S1. No nerve involvement was described on the MRI. His EMG was felt to be consistent with a right L5 radiculopathy. It is not clear if his provider performed any epidural injections upon him. He underwent an FCE in November 2008 and repeated in January 2009 and March 2009. He improved and reached a medium to medium heavy PDL level. His job apparently requires a higher level of function. He completed 19 sessions of a work hardening program per Dr. Another reviewer cited 21 sessions. Dr. wrote:

“Mr was discharged from the work hardening program as he met one of the exit criteria per protocol. ...his progression has plateaued.....Mr. appears to be focused on his pain.” Ms. initially described him as a good candidate for the work hardening program and now for the pain management program. Dr. is appealing the prior denials for 20 sessions of pain management.

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

Records indicate this patient has chronic pain. The patient has already participated in a work hardening program. ODG states: *“(10) Upon completion of a rehabilitation program (e.g. work hardening, work conditioning, outpatient medical rehabilitation) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury.”*

The ODG considers a chronic pain program to be similar to a work-hardening program. It states in the criteria for pain management programs, that: *“(13) At the conclusion and subsequently, neither re-enrollment in repetition of the same or similar rehabilitation program (e.g. work hardening, work conditioning, out-patient medical rehabilitation) is medically warranted for the same condition or injury (with possible exception for a medically necessary organized detox program). Prior to entry into a program the evaluation should clearly indicate the necessity for the type of program required, and providers should determine upfront which program their patients would benefit more from.”*

The ODG states 20 sessions of a pain program may be appropriate for some patients, but only after an initial 10-session assessment. This request for 20 sessions exceeds the recommended amount. The ODG states: *“(10) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains.”*

The reviewer finds that medical necessity does not exist for Chronic Pain Management Program 5xwk x 4wks (97799).

### **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)