

Becket Systems

An Independent Review Organization
815-A Brazos St #499
Austin, TX 78701
Phone: (512) 553-0533
Fax: (207) 470-1075
Email: manager@becketystems.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: October/02/2011

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:

MD, Board Certified Family Practice

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 07/25/11, 08/22/11
MRI lumbar spine dated 01/03/03, 09/18/04
Review of MRI dated 09/27/04
Handwritten initial intake dated 10/25/04
Operative report dated 01/30/03, 02/07/03, 02/21/03, 05/26/05
Designated doctor evaluation dated 03/28/03
Electromyography testing dated 04/29/03
Evaluation dated 02/11/04, 09/02/04, 11/09/04, 06/24/11, 07/22/11
Vocational intake form dated 08/15/11
Appeal letter dated 08/04/11
PPE dated 07/06/11
Psychological evaluation dated 07/06/11
Precertification request dated 07/14/11
Letter dated 09/09/04, 11/01/04, 11/08/04, 04/21/05, 07/11/05
Handwritten follow up visit dated 11/23/04, 12/21/04, 01/18/05, 02/15/05, 05/09/05, 05/26/05, 06/22/05, 10/25/05
Medication contract dated 06/24/11
Radiographic report dated 07/11/04, 04/26/04
Neurosurgical evaluation dated 08/31/04, 02/17/05

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xxxx. On this date the patient was installing a differential when he hurt his lower back. Treatment to date includes diagnostic testing, epidural steroid injections, bilateral L4-5 and L5-S1 hemilaminectomy and foraminotomies on 05/26/05, postoperative physical therapy and work hardening program. Designated doctor evaluation dated 03/28/03 indicates that the patient has not reached MMI and was recommended for EMG/NCV. Evaluation dated 06/24/11 indicates that the patient is unsure if he has previously completed a chronic pain management program. PPE dated

07/06/11 indicates that current PDL is sedentary and the patient's work place did not furnish a job explanation or demands sheet for the testers. Psychological evaluation dated 07/06/11 indicates that medications include Tramadol and ibuprofen. BDI is 28 and BAI is 18. Diagnosis is pain disorder. Initial request for chronic pain management program was non-certified on 07/25/11 noting that the length of time that the patient is removed from the date of injury would be considered a negative predictor with respect to a successful outcome from such an extensive program.

An appeal letter dated 08/04/11 states that this patient has been working approximately 12 hours per week with a light PDL, which will not interfere with the program. However, the denial was upheld on appeal dated 08/22/11 noting that it remains unclear why such an extensive treatment program would be needed for an individual with an old injury who has been working for years. There is no evidence to indicate that the treatment team has exhausted all appropriate treatments for this patient.

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

The records fail to establish that this patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program. There is no comprehensive assessment of recent treatment completed to date or the patient's response thereto submitted for review. There is no indication that the patient has undergone a course of individual psychotherapy or been placed on psychotropic medications for treatment of psychological symptoms. The patient is noted to have worked for years. The submitted functional capacity evaluation is nonspecific for return to work required functional abilities as the patient's employer did not provide a job explanation or demands sheet for the testers. The Official Disability Guidelines do not generally support chronic pain management programs for patients whose date of injury is greater than 24 months old as there is conflicting evidence that these programs provide return to work beyond this period. The reviewer finds there is not a medical necessity 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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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