

# Becket Systems

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Sep/19/2011

**IRO CASE #:**

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

10 Chronic Pain Management program visits over 1 month for the low back

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

MD, Board Certified Physical Medicine and Rehabilitation

**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 08/03/11, 08/29/11, 07/11/11

Functional capacity evaluation dated 02/17/11

Follow up note dated 12/01/2010, 10/13/10, 07/07/10

Handwritten progress notes dated 11/22/10, 11/17/10, 10/20/10, 10/12/10, 09/28/10, 09/14/10, 12/20/10

Individual counseling session note undated

Progress note dated 04/28/11, 03/31/11, 03/03/11, 01/20/11, 06/15/11, 05/31/11

Appeal letter dated 07/19/11

Adverse determination notice dated 07/05/11

Work hardening progress note dated 05/16/11

Psychological evaluation dated 04/29/11

Notice of appeal dated 08/25/11

Procedure note dated 09/29/10

Letter dated 08/31/11, 10/18/10

Designated doctor evaluation dated 01/18/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female whose date of injury is xx/xx/xxxx. On this date the patient lifted a 7 lb bin and turned to the right when she developed low back pain. Treatment to date includes epidural steroid injections, diagnostic testing, physical therapy, and medication management. Designated doctor evaluation dated 01/18/11 indicates that the patient was referred for a work hardening program. Extent of injury extends to include facet sprain right lower back with sacroiliac dysfunction. Anticipated MMI date is 04/18/11. Functional capacity evaluation dated 02/17/11 indicates current PDL is sedentary and required PDL is medium. Psychological evaluation dated 04/29/11 indicates that BDI is 16 and BAI is 26. The patient completed a work hardening program. Progress note dated 05/16/11 indicates that BDI is 26 and BAI is 35. Work level remains sedentary.

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

The patient has undergone extensive physical therapy as well as a work hardening program without significant improvement. In fact, the submitted records indicate that the patient actually digressed in the work hardening program. There is no clear rationale provided as to why a chronic pain management program would provide significant benefit when a previous multidisciplinary program was not beneficial for this patient. The Official Disability Guidelines note that upon completion of a rehabilitation program such as work hardening, neither reenrollment in or repetition of the same or similar rehabilitation program is warranted. ODG states that chronic pain management program should not be considered a stepping stone after less intensive programs. The reviewer finds there is no medical necessity for 10 Chronic Pain Management program visits over 1 month for the low back.

**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)