

# Becket Systems

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Oct/21/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** additional chronic pain management x 80

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

**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 additional chronic pain management x 80 is not recommended as medically necessary.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines  
Utilization review determination dated 07/26/13, 08/22/13  
Request for reconsideration dated 08/15/13  
Progress summary dated 07/17/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. The mechanism of injury is described as a fall. Progress summary dated 07/17/13 indicates that the patient has completed 7 of 10 authorized sessions of chronic pain management program. The patient continues to recognize and practice the learned natural restorative techniques to the best of his ability to manage more effectively his pain and stress. He has made further progress in his ability to utilize his emotional energy within group discussions and assignments maintaining more appropriate boundaries. Pain level has decreased from 7/10 to 4/10. BDI decreased from 17 to 16 and BAI increased from 13 to 25. FABQ-PA is 24 and FABQ-W is 42.

Initial request for additional chronic pain management x 80 was non-certified on 07/26/13 noting that there is little change in depression index and the BAI has increased. The claimant stated that he is using his medication on an 'as needed' basis. There is no compelling rationale provided in the report and no daily notes from the chronic pain management program to review. The denial was upheld on appeal dated 08/22/13 noting that there is no documentation provided that shows progress or improvement towards a required PDL for this claimant on a prior and recent functional evaluation. A recent PPE or functional capacity evaluation has not been performed or provided with findings to support the current request.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND**

**CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient has completed 7 of 10 authorized chronic pain management program sessions without significant progress documented. The submitted records indicate that the patient's BDI decreased only slightly from 17 to 16 and BAI actually increased from 13 to 25. There is no updated functional capacity evaluation/PPE or physical examination submitted for review to establish functional improvement. The Official Disability Guidelines support treatment beyond the initial trial of chronic pain management program only with evidence of objective functional improvement, which is not documented in the submitted clinical records. As such, it is the opinion of the reviewer that the request for additional chronic pain management x 80 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)