

Becket Systems

An Independent Review Organization
815-A Brazos St #499
Austin, TX 78701
Phone: (512) 553-0360
Fax: (207) 470-1075
Email: manager@becketsystems.com

DATE NOTICE SENT TO ALL PARTIES: Nov/16/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: chronic pain management program 80 hours/units

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DC, Licensed Chiropractor

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 chronic pain management program 80 hours/units is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is XX/XX/XX. The patient was stepping down from a ladder with about 60 pounds of equipment when he felt immediate pain in his low back. The patient completed 40 hours of physical therapy, 20 hours of work conditioning and 80 hours of work hardening program. The patient completed 12 individual psychotherapy sessions and 6 biofeedback sessions. Treatment to date also includes SI injection and rhizotomy. Current medications are Ambien and Baclofen. BDI is 22 and BAI is 16. PPE dated 09/28/15 indicates that the patient has been off work since 08/02/13. Required PDL is very heavy and current PDL is heavy. Health and behavioral reassessment and psychological testing dated 10/01/15 indicates that BDI is 22 and BAI is 16. MMPI protocol is valid. Diagnoses are somatic symptom disorder with predominant pain, major depressive disorder and unspecified anxiety disorder.

Initial request for chronic pain management program 80 hours was non-certified on 10/13/15 noting that it is documented that presently the patient would be capable of heavy duty work activities. The length of time the claimant is removed from the date of injury would be considered a negative predictor of a positive response from such an extensive program. Reconsideration request dated 10/20/15 indicates that the cautionary statement in the Official Disability Guidelines should not preclude patients off work for over two years from being admitted. The denial was upheld on appeal dated 10/27/15 noting that since the claimant is already capable of work duties in the heavy PDL the patient should be capable of a return to work duties as recommended by the evidence-based guidelines. The patient's date of injury is over xxxxx. The negative predictors have not been addressed. Documentation that the patient is willing to change has not been provided. There is no evidence of attempts to return the claimant to modified work duties or full duty work status prior to the current request.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries over xxxxxx xxxxx ago on XX/XX/XX and has not worked since XX/XX/XX. The patient has

undergone extensive treatment including work conditioning and work hardening program and has been unable to return to work. The Official Disability Guidelines do not support re-enrollment in or repetition of the same or similar rehabilitation program and note that chronic pain management programs should not be used as a stepping stone after completion of less intensive programs. The patient is currently capable of returning to work at the heavy physical demand level; however, there is no documentation of return to work attempts. The chronicity of the injury and the lack of work history in over two years are negative predictors. The patient is not currently taking any opioid or psychotropic medications. As such, it is the opinion of the reviewer that the request for chronic pain management program 80 hours/units is not recommended as medically necessary and the prior denials are upheld.

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)