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: Feb/12/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Chronic pain management program x 10 sessions

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

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] 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 x 10 sessions is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is XX/XX/XX. On this date the patient was pushed down and fell on the sidewalk, hitting her head. She states she held out her hands to break her fall and her left wrist was also injured. Post designated doctor's required medical examination dated XX/XX/XX indicates that with reference to the cervical sprain, lumbar sprain and facial abrasions she is at a point of reasonable stability. However, there are some unanswered questions as the patient should have been referred for MRI of the left wrist. Behavioral evaluation dated XX/XX/XX indicates that treatment to date includes x-rays, physical therapy x 6 and individual psychotherapy x 6 sessions. Current medications are Plaquenil, tramadol and lisinopril. BDI is 16 and BAI is 31. Office visit note dated XX/XX/XX indicates that diagnoses are lumbar strain and lumbosacral sprain. Physical examination is unchanged since last office visit. Functional capacity evaluation dated XX/XX/XX indicates that current PDL is light. The report states, "XX is presently able to work full time."

Initial request for chronic pain management program x 10 sessions was non-certified on XX/XX/XX noting that a chronic pain management program is not supported for strain/sprains and contusions. The patient has not reportedly attempted to return to work and is not taking narcotic medication. Appeal dated XX/XX/XX indicates that the chronic pain program is considered a functional restoration program.
This program will also provide the patient with coping skills to deal with her pain reports of 7/10. The patient is taking tramadol which is a synthetic opiate. The denial was upheld on appeal dated XX/XX/XX noting that the patient has had a functional past evaluation which documents light physical demand level and the ability to work full-time. She apparently has not had a full duty return to work trial. This is considered preferable to work hardening or chronic pain management according to ODG.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained sprain/strain injuries on XX/XX/XX. The submitted records fail to establish that the patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program as required by the Official Disability Guidelines. The submitted functional capacity evaluation dated XX/XX/XX states that, XX is presently able to work full time." There is no documentation of unsuccessful return to work attempts. As such, it is the opinion of the reviewer that the request for chronic pain management program x 10 sessions 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)