# Becket Systems
**An Independent Review Organization**
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**November 5, 2018**

***Description of the service or services in dispute:***
XX

***Description of the qualifications for each physician or other health care provider who reviewed the decision:***
Board Certified in Pain Management

***Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:***
☐ Overturned (Disagree)
☑ Upheld (Agree)
☐ Partially Overturned (Agree in part / Disagree in part)

***Patient Clinical History (Summary)***
XXXX who sustained a work-related injury on XXXX. The injury resulted from a XXXX. The activity involved XX that occurred at work. XXXX was diagnosed with XX, XX.

On XXXX for a follow-up of XX pain, medication management, and continuation of care. The symptoms were located in the entire XX and included XX pain, XX XX, XX spasm, XX XX of XX and XX pain. The pain radiated to the XX XX, XX XX, XX XX, and XX XX. It was described as XX and XX with gradual onset. The episodes occurred XX. XXXX described the symptoms as XX in severity and unchanged, rated at XX/10. The symptoms were exacerbated by turning the XX to the XX and to the XX. The relieving factors included heat. The associated symptoms included a XX and XX extremity XX (XX XX, with XX and XX in the XX XX). XXXX was not being treated for this problem at the time. By report, there was poor compliance with treatment. XXXX was unable to work or do XX at the time. On XX XX examination, there was moderate tenderness of the XX XX muscles. Trigger points were noted at the XX XX and XX XX. The range of motion was decreased in flexion and XX XX flexion, due to pain.

The treatment to date included medications (XXXX) with XX improvement, XX therapy (XX), and XX XX in XXXX.

Per a utilization review decision letter dated XXXX, the request for XX XX XX XX XX XX at XX-XX with XX and XX was denied by XXXX with the following rationale: "In my judgment, the available information does not support the medical necessity of this request. This request is

not supported by the Official Disability Guidelines XX and XX XX Chapter: XX XX XX (XX) as well as the Pain Chapter: XX XX XX (XX). The guideline would recommend an XX XX XX following failure of conservative therapy with neurologic deficient on examination and corroboration from imaging and / or XX testing. There were no specific neurologic deficit findings at the level requested nor corroboration from imaging. Therefore, an adverse determination of the request for XX at XX-XX with XX and XX is recommended."

Per a utilization review decision letter dated XXXX, the prior denial was upheld by XXXX. Rationale: "In my judgment, the clinical information provided does not establish the medical necessity of this request. This request is not supported by the Official Disability Guidelines XX and XX XX Chapter: XX XX XX (XX), and the Official Disability Guidelines, Pain (Chronic) Chapter. Per the Official Disability Guidelines, XX, and XX XX Chapter, XX XX XX (XX), "Not recommended based on recent evidence, given the serious risks of this procedure in the XX region, and the lack of quality evidence for sustained benefit." In this case, there is no documentation of exceptional factors to support an XX XX XX outside the current evidence-based guideline recommendations that specifically indicate lack of support for this procedure, especially at the level of XX-XX. The guidelines also do not recommend sedation except for injured workers with XX, which is not indicated here. Therefore, the request for a XX XX XX XX XX XX at XX-XX with XX and XX is not medically necessary at this time."

***Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.***

The records were reviewed to determine whether the requirements for an XX under the ODG were met. XX All of these requisite criteria are lacking in the records reviewed.

Two prior utilization reviews were performed, which could not support the requested procedure. There are no exceptional factors that warrant going outside the ODG. Given the documentation available, the requested service(s) is considered not 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 and Environmental Medicine

☐ AHRQ-Agency for Healthcare Research and Quality Guidelines

☐ DWC-Division of Workers Compensation

☐ Policies and Guidelines European Guidelines for Management of Chronic XX XX Pain

☐ Interqual Criteria

☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards

☐ Mercy Center Consensus Conference Guidelines

☐ Milliman Care Guidelines

☐ ODG-Official Disability Guidelines and Treatment Guidelines

*ODG-TWC ODG Treatment: Integrated Treatment/Disability Duration Guidelines XX and XX XX; (updated XX)*

*XX XX XX (XX)*

*XX*

- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)

**Appeal Information**

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.