Becket Systems

An Independent Review Organization
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Notice of Independent Review Decision

Review Outcome

Description of the service or services in dispute:

X

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified X

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

X

Patient Clinical History (Summary)

X is a X who was injured on X, when X. The diagnosis was X.
X was evaluated by X on X for X. X presented for X. X reported X. X stated X after X. The symptoms were X and had not X. At the time, the pain was rated X. Examination noted pain with X. The assessment was X. X was X with the results of X and wished to X. X had been able to X. X continued to have some X but X.

X of the X dated X showed X. An MRI of the X dated X, identified X. There was no significant X. X were X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X. Rationale: “Based on the medical records submitted for review on the above referenced claimant, X is NON-AUTHORIZED. The patient had X approved X. Office notes X stated X. X Office Visit Note documents X. Official Disability Guidelines does not recommend X more than X.

Per a reconsideration review adverse determination letter dated X, X, MD non-authorized reconsideration for X as not medically necessary. Rationale: “Based upon the medical documentation presently available for review, Official Disability Guidelines would not support a medical necessity for this specific request as submitted. The records available for review indicate that in the recent past, X. The submitted clinical documentation does not provide specifics to indicate whether X were X with respect to X. Multiple attempts at conducting a PEER to PEER review were not successful. As a result, presently, for the described medical situation, Official Disability Guidelines would not support a medical necessity for this specific request as submitted. As documented above, multiple attempts at conducting a PEER to PEER review were not successful.”

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

Based on the clinical information provided, the request X as medically necessary, and the previous denials are overturned. The submitted clinical records indicate that the patient underwent X. The patient reported X. The patient subsequently underwent X, but X. The patient reports X that X. Given the patient's X response to X and the presence of X, the request is 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 Low Back 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
- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- ☐ 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.