Becket Systems
An Independent Review Organization
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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:
X

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

Information Provided to the IRO for Review
X

Patient Clinical History (Summary)
X with date of injury X. X sustained a work-related injury while working as an X. X work consisted of X.

On X, X was seen by X, MD. X complained of X. X took X had X. The pain was X. On examination, X. There was X were noted and X. On X, a X dated X was reviewed, which showed evidence of X.

A X evaluation was performed by X, PhD and Dr. X on X. X reported primary location of X pain was in X. The pain X. The pain was X. X rated the pain X. The pain X. X reported that X. X symptoms included X. The X, within the X. The X, within the X. The X for Patients in X. The X Dr. X opened that the pain resulting from X. X reported X related to the pain and pain behavior, in addition to X. Pain had reported X. X would benefit from a course of X.

A X Evaluation was completed by X, X on X. During X testing, X demonstrated X. X Pain results obtained during testing indicated X. X demonstrated the X. X was able X. X were evaluated and X. X demonstrated an X. X demonstrated the X. The functional activities X should X.

The treatment to date included X.

Per a peer review by X, MD dated X, the request for X was denied. Rationale: “The documentation appears to contain contradictory information. The behavioral health evaluation report from X suggests that the patient is X. The report notes that the patient X. This information with suggest that the patient is X. However, the functional capacity evaluation from X indicates that the patient is an X. Ability to X. Further clarification is required regarding the patient's capabilities prior to additional consideration for treatment of this nature. Considering this information, the medical necessity is not supported. Therefore, my recommendation is to NON-CERTIFY the request for X.”

Per a peer review by X, MD dated X the request for X was denied. Rationale: “Peer discussion was performed on X with X, LPC. The nature of the patient's repetitive injury involving the X was appreciated. Fortunately, X employer of more than X. It was agreed that advancing X restrictions and returning the patient to X prior work duties would not be in X best interest as this would potentially result in a recurrence of X. The patient does not utilize any X. X does have some X; however, it was agreed that this could be addressed with a X. Therefore, my recommendation is to NON-CERTIFY the APPEAL for X.”

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

I reviewed the patient’s medical record and the results of the two prior utilization reviews. These reviews appear to be accurate and raise a question as to the necessity of a X. The statement by the physical therapist that the patient is X. In addition, the second review states that

a different X, was agreed upon with the counselor. The patient may be eligible for X at a future date, if X is not effective, and the patient cannot X. 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 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.