

Becket Systems  
*Notice of Independent Review Decision*  
Becket Systems  
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*Notice of Independent Review Decision*

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*Sent to the Following*

**IRO REVIEWER REPORT**

**Date: X**

**IRO CASE #: X**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X.**

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH  
PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO  
REVIEWED THE DECISION: X**

**REVIEW OUTCOME:**

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

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- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)
- Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute

#### **INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X**

**PATIENT CLINICAL HISTORY [SUMMARY]:** X who was injured on X. X stated that while outside of the X. A couple of hours later, X. The diagnoses were unspecified fracture of fourth metacarpal bone, right hand, initial encounter for closed fracture; lumbar sprain / strain; X disc herniation; X disc herniation; lumbar radiculopathy; sacroiliac joint sprain; right hip sprain / strain; right thumb MCP sprain; olecranon bursitis right elbow; anxiety, major depressive disorder and acute posttraumatic stress disorder (PTSD).

Per a Mental Health Re-Assessment dated X completed by X, MS, LPC, stated that X presented to assess progress and determine whether mental health factors were inhibiting treatment benefit and ability to return to work in a complete capacity and to

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determine if X would benefit from a X. X stated the event which precipitated this pain occurred during X typical work routine. X was outside of X. A couple of hours later the X. X was being treated with X. X continued to report high levels of pain. The assessment results included that X had exhibited symptoms of stress and anxiety during the course of the clinical interview. X affect was apprehensive, and X voice and demeanor reflected a high level of anxiety. X scored a X on the Beck Depression Inventory-II, indicating moderate depression. This was an increase of X points from X previous assessment for the X. X scored a X on the Beck Anxiety Inventory, indicating moderate anxiety. This increased by X points from X previous assessment for the X; X previous score was X, indicating moderate anxiety. A patient with moderate scores should address coping strategies and stress management as part of the X. Additional assessment results included on Fear-Avoidance Belief Questionnaire, X scored a median score (X) on the physical activity portion of the assessment and a median score (X) on the work portion of the assessment. On Pain Impairment Rating Scale, showed X rated X pain as X at its worst, X at its least and X on average. Regarding importance and confidence scale, X reported on X being very important to X to reduce and manage X pain more effectively; X low importance to X to return to work. X reported X in high confidence in X motivation to reduce and manage X pain more effectively. X reported on X low confidence in X ability to return to work with X ongoing management of X pain. Mental status examination revealed X appeared stated age, appropriately

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dressed and groomed. Psychomotor activity showed movements were somewhat stilted and stiff, activity level was reduced. Speech was normal, good volume and clear. Attitude to examiner was cooperative and friendly. Mood was normal. Affect was anxious and apprehensive. Perceptual abnormalities included no apparent evidence of a perceptual disorder or hallucinations. X denied and none were evident. Thought content showed no evidence of a thought pattern that would suggest the presence of obsessive / compulsive traits, behaviors, delusions, phobias or symptoms. Thought process showed there was no evidence of thought disorder. Thoughts were organized, goal directed, and coherent. Sensorium and cognition showed alert and oriented to person to place, and situation. Estimated intellectual functioning was average. Memory and concentration were within normal limits. Insight was good understanding of problems, fair coping skills. Judgment was good, able to understand facts. The assessment was chronic pain, situational depression, anxiety related to X injury and concern over X vocational future; low energy due to lack of quality of sleep, financial stress, lack of coping skill, agitated state over concerns for future and feeling lack of control. It was concluded that at the ongoing time, X was recommended to attend X sessions the X. X motivation was high; however, X was having difficulty adjusting to X present health situation. X was strongly recommend attending X.

Per a Functional Capacity Evaluation report dated X completed by

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X, DC, stated that X presented for evaluation to reassess X ability to return to work and/or the need for additional rehabilitation. X had relayed the onset to have occurred on X. X stated that while outside of the X. A couple of hours later, X. Ongoing chief complaint included X had intermittent pain in the right hand and constant pain in the right thumb. X reported the intensity of the pain to be X for the left hand and X for the right thumb. X stated that grasping, holding, making a fist and associated with normal daily activities would increase X pain. X stated that medication helped to decrease X overall pain level. X had constant pain in the low back with a sharp pain into X right hip. X reported the intensity of the pain to be X. X stated that prolonged sitting / driving, bending, lifting, getting up from a seated or laying down in certain positions and activities associated with normal daily activities, would increase X overall pain level. X stated that laying / resting, soaking in a hot tub and medication had helped to decrease X overall pain level. X also had constant pain in the right hip.

X reported the intensity of the pain to be X. X stated that laying on the right side, sitting (improved) and activities had associated with normal daily activities would increase X overall pain level. X stated that medication, shifting X weight to the left and laying on the left side would help to decrease X overall pain level. Physical examination revealed X was well developed and well nourished. There was mild antalgic gait with guarding of the lumbar spine. There was callous formation of the right 4th metacarpal with no

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surrounding edema present. The postural evaluation revealed shifting of weight with sitting and having to stand after sitting X minutes due to pain. Right hand examination revealed mild pain over the fourth metacarpal and moderate pain over the ulnar aspect of the right thumb metacarpophalangeal (MP) joint. Lumbar spine and paraspinal musculature revealed moderate right lumbosacral pain and mild right paraspinal hypertonicity. Right hip and musculature revealed mild pain at the greater trochanter and mild-moderate myalgia of the gluteus medius. Neurological examination revealed deep tendon reflex testing was X at biceps, brachioradialis, triceps, patellar and Achilles bilaterally. Deep tendon reflexes were absent at hamstring bilaterally. Sensory examination showed light touch was clinically unremarkable at the time of the evaluation. Motor examination revealed a grade X strength rating involving right thumb extension, right hip flexion, right hip abduction, lumbar flexion and extension, right foot inversion and eversion. Lumbar spine examination revealed Valsalva was positive. Slump test was positive on the right. Kemp's test was positive on the right for ipsilateral facet joint pain and on the left for contralateral paraspinal myalgia and spasm. Straight leg raise (SLR) test was positive for lumbosacral and low back pain when performed on the right at X degrees. Double leg raise was positive for lumbosacral pain. Hibb's test was positive on the right for sacroiliac joint pain. Right hip examination revealed FABER, FADIR and Ober's test were positive. Right thumb UCL testing elicited moderate pain and mild laxity. Lumbar spine active range of

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motion revealed flexion was X degrees, extension X degrees, right lateral flexion X degrees and left lateral flexion X degrees. Right hip active range of motion revealed flexion was X degrees, extension X degrees, abduction X degrees, adduction X degrees, internal rotation X degrees and external rotation X degrees. Right wrist active range of motion revealed flexion was X degrees, extension X degrees, ulnar deviation X degrees and radial radiation X degrees. Right ring finger distal interphalangeal joint range of motion revealed flexion X degrees and extension X degrees; proximal interphalangeal (PIP) joint range of motion revealed flexion to X degrees and extension X degrees; and metacarpophalangeal (MP) joint range of motion revealed flexion X degrees and extension +X degrees. Functional capacity evaluation results included X occupation was as a X. X occupation's job demand was medium physical demand level. At the time, X was performing at light to light-medium physical demand level. X was capable of performing at a Light to Light-Medium physical demand level involving the injured area(s) and continued to experience a mild-to-moderate functional deficit as it related to meeting the sitting / driving (currently occasional vs constant), bending (currently occasional versus frequent job requirement), climbing (currently occasional versus frequent job requirement), floor lifting (currently X pounds versus X pounds job requirement), floor to shoulder lifting (currently X pounds versus X pounds job requirement), floor to overhead lifting (currently X pounds versus X pounds job requirement), two hand carrying (currently X pounds versus X pounds job requirement),

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pushing (currently X pounds versus X pounds force required job requirement) and pulling (currently X pounds versus X pounds force required job requirement) job criteria as defined by the Dictionary of Occupational Titles and / or X Job Description Interview. Recommendations included X had completed X of X additional X with the following gains: lumbar flexion and extension, right hip adduction, right hip internal rotation, right ring finger distal interphalangeal (DIP) joint flexion, floor to shoulder lifting (from X pounds to X pounds), floor to overhead lifting (from X pounds to X pounds), two hand carrying (from X pounds to X pounds), pushing (from X pounds to X pounds) and pulling (from X pounds to X pounds). X had demonstrated the following regressions: lumbar right lateral flexion, right hip flexion, right ring finger proximal interphalangeal (PIP) joint flexion, right ring finger MP (metacarpophalangeal) flexion and extension. X X mental health evaluation revealed a Beck Depression Inventory (BDI) of X /X (X on X, X on X) indicating moderate depression, Beck Anxiety Inventory (BAI) of X (20/63 on X, (X on X) indicating moderate anxiety, FABQPA of X (X on X, X on X) and a FABQWP of X on X, X on X) indicating continued maladaptive fear avoidance behavior with physical activity and unchanged with work activity. While X had demonstrated an increase in X physical and functional abilities during the initial X hours of the X, X had struggled with regard to the mental barriers involved with X ability to return to work as well as the financial issues, family and social issues related to X work-related injury, especially toward the latter stages of X when the volume of X

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workload and especially, work simulation was increased. This was evidenced physiologically by the following: increased VAS both sitting and standing, increased heart rate with both sitting and standing and increased RPE. The negative impact of X chronic pain had affected X psychologically as evidenced by the increased depression and anxiety. Based on the results of this exam and considering the X mental health evaluation, it would be agreed with the recommendation of the mental health evaluation (MHE) that an X program would be appropriate for X as X met at least X of the X criteria for multidisciplinary pain management programs as defined by the ODG and other methods of treating chronic pain had been unsuccessful and there were no other options for X that were anticipated to result in clinical improvement. The X program would allow time to address X continued moderate depression and increased anxiety while continuing to build on X functional / physical gains.

On X, X was seen by Dr. X, for chief complaint of work-related multiple injuries. X presented for re-evaluation. The ongoing complaints included intermittent pain in the right hand with movement of the right ring finger as well as pain continued popping out of place / triggering of the right thumb. X reported popping with making a fist (demonstrated as well). X reported the intensity of the pain to be X for the hand and X for the right thumb. X stated that X was trying to grasp or hold with activity associated with normal daily activities, still increased X pain. X stated that medication had helped to decrease X overall pain

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level. X had frequent pain in the low back which shoots up into X upper back as well as sharp pain into X right lower extremity to the buttock and hip and sometimes down to the right foot, but lately not to the inside of the thigh. X stated that the pain in worse in the morning. X reported the intensity of the pain to be X. X stated that prolonged sitting / driving, bending, getting up from a seated or laying down position and activities associated with normal daily activities increased X overall pain level. X stated that laying / resting, soaking in a hot tub and medication helped to decrease X overall pain level. X had intermittent pain in the right hip. X reported the intensity of the pain to be X. X stated that laying on the right side, sitting, twisting and activities associated with normal daily activities increased X overall pain level. X stated that medication, using H-wave and laying on the left side had helped to decrease X overall pain level. X also reported infrequent headaches (VAS X) and continued nightmares, but better sleeping. Burning smells had triggered some anxiety. X had no right elbow pain. Physical examination revealed X had well developed, well-nourished. Mental status revealed X was oriented to time, place and person. Mood appeared calm. Gait evaluation revealed very mild antalgic gait. There was no swelling of the right hand over the 4th metacarpal on the day nor at the right olecranon. Right hand revealed minimal pain over the fourth metacarpal and moderate pain over the ulnar aspect of the right thumb MP joint. Lumbar spine and paraspinal musculature revealed mild-moderate right lumbosacral pain, mild right paraspinal myalgia, mild right

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sacroiliac (SI) joint pain and mild right paraspinal hypertonicity. Right hip and musculature revealed mild pain at the greater trochanter and mild-moderate myalgia of the gluteus medius. Right elbow revealed no pain to palpation. Neurological examination revealed deep tendon reflex testing revealed strength of X biceps, brachioradialis, triceps, patellar and Achilles bilaterally and at hamstring it was absent bilaterally. Sensory examination showed light touch was clinically unremarkable at the time of the evaluation. Motor examination revealed a grade X strength rating involving right thumb extension; right hip flexion, right hip abduction; lumbar flexion and extension; right foot inversion and eversion. Lumbar spine examination revealed Valsalva was positive. Slump test was positive on the right. Kemp's test was positive on the right for ipsilateral facet joint pain and on the left for contralateral paraspinal myalgia and spasm. Straight leg raise (SLR) test was positive for lumbosacral and low back pain when performed on the right at 60 degrees. Double leg raise was positive for lumbosacral pain. Hibb's test was positive on the right for sacroiliac joint pain. Right hip examination revealed FABER test was positive. Right thumb UCL testing elicited moderate pain and mild laxity. Lumbar spine active range of motion revealed flexion was X degrees due to pain in the lumbosacral region, extension X degrees due to pain in the right facet joints and lumbosacral region, right lateral flexion X degrees and left lateral flexion X degrees with stiffness reported. Right fourth digit was minimally restricted. Right thumb range of motion showed interphalangeal (IP) flexion was X degrees due to

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MP pain, interphalangeal (IP) extension was X degrees, MP flexion was X degrees with pain at MP joint, MP extension was X with pain at MP joint, adduction was X cm with pain at MP joint, radial abduction was X due to pain at MP joint. Right hip range of motion revealed flexion was X degrees due to pain in the right lateral hip, extension X degrees due to pain in the right groin, abduction X degrees due to pain at the greater trochanter and gluteus medius, adduction X degrees due to pain at the greater trochanter and gluteus medius, internal rotation X degrees and external rotation X degrees due to pain at the greater trochanter and gluteus medius. Right elbow range of motion revealed flexion was X degrees, extension X degrees, supination X degrees and pronation X degrees. On assessment, X had completed a X. Prognosis was guarded pending participation in chronic pain management program.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, PhD, the request for X was denied. Rationale: "Request is well beyond Official Disability Guidelines by MCG (ODG) (work hardening criterion #21). Patient has exhausted treatments."

On X, X, had placed an appeal regarding denial for request of X.

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Dr. X stated regarding the non-certification recommendation: X had participated previously in a X. However, as stated in the X FCE, X demonstrated an increase in X physical and functional abilities during the initial X hours of the X. However, X struggled to progress during the X. The attributing factor was increased chronic pain. In this particular case, the ODG stated that participation in a previous work hardening program did not preclude participation in a chronic pain management program. Additionally, X met at least X of the X criteria for multidisciplinary pain management programs as defined by the ODG and other methods of treating chronic pain had been unsuccessful and there were no other options for X that were anticipated to result in clinical improvement. Therefore, Dr. X requested reconsideration of the denial for the X.

Per a reconsideration / utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "Per Official Disability Guidelines by MCG (ODG), "At the conclusion and subsequently, neither re-enrollment in repetition of the same or similar rehabilitation program (e.g., work hardening, work conditioning, out-patient medical rehabilitation) is medically warranted for the same condition or injury (with possible exception for a medically necessary organized detox program). Prior to entry into a program the evaluation should clearly indicate the necessity for the type of program required, and providers should determine upfront which program their

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patients would benefit more from. A chronic pain program should not be considered a "stepping stone" after less intensive programs, but prior participation in a X." Also, per ODG, "X: Upon completion of any rehabilitation program including X, X, X is medically warranted for the same condition or injury." In this case, prior treatment included X. The ODG guidelines indicate that prior participation in X may not preclude an opportunity to enter a X, but also note that if a X has reached "conclusion" that a similar rehabilitation program is not recommended. The records do not explain how the X would be substantially different in content from the X or why it would be expected to be successful when the last X. The records also do not explain why a X was initially thought to be more appropriate for the patient or if there have been any changes in clinical circumstances to reflect that a X would have been the more appropriate treatment option for the individual. The request is not shown to be medically necessary. Therefore, the requested X is nonauthorized."

On X, Dr. X, had placed an appeal regarding denial for request of X. Dr. X stated regarding the non-certification recommendations: X had participated previously in a X. However, as stated in the X FCE, X demonstrated an increase in X physical and functional abilities during the initial X. However, X struggled to progress during the X. The attributing factor was increased chronic pain which then led to increases in anxiety, depression and furthered fear-avoidance behavior. Regarding appropriateness of X, X

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demonstrated good initial progress in the X. Regarding medical necessity for the X and as stated previously, as the workload increased and X started to display some plateau and/or regression, this lead to increases in anxiety, depression and fear-avoidance behavior which would be addressed more intensely with the X (X) while applying the coping skills concurrent with physical activity. Additionally, the ODG stated that participation in a X did not preclude participation in a X and X met at least X of the X criteria for multidisciplinary pain management programs as defined by the ODG and other methods of treating chronic pain had been unsuccessful and there were no other options for X that were anticipated to result in clinical improvement. Therefore, Dr. X requested reconsideration of the denial for the XX.

Thoroughly reviewed provided records including provider notes and peer reviews.

Provider has repeatedly documented criteria that has been cited by peer reviews in regards to the additional chronic pain management program hours. Patient is having continued complex pain issues that are preventing them from successful recovery. At the same time, some progress has been noted. Thus, request for X is warranted. The requested X is medically necessary and certified

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO**

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#### **SUPPORT THE DECISION:**

Thoroughly reviewed provided records including provider notes and peer reviews.

Provider has repeatedly documented criteria that has been cited by peer reviews in regards to the X. Patient is having continued complex pain issues that are preventing them from successful recovery. At the same time, some progress has been noted. Thus, request for X is warranted. The requested X is medically necessary and certified

#### **A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

**AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

**DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

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- 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
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & 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)