

Becket Systems

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/29/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

AP and lateral Lumbar X-Ray

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

M.D., Board Certified in Orthopedic Surgery

REVIEW OUTCOME:

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

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW

xxxxx, 2/10/10, 2/16/10

M.D. 2/8/10, 1/5/10, 7/14/09, 7/1/09, 6/22/09, 6/18/09, 6/11/09, 5/14/09, 4/29/09, 4/15/09, 4/9/09, 3/19/09, 3/12/09, 3/5/09, 2/26/09

xxxxx 11/23/09, 7/6/09

xxxxx 7/7/09, 4/27/09, 4/3/09, 3/5/09

xxxxx 2/10/10, 2/16/10

ODG-TWC

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who has undergone a lumbosacral fusion with implantable bone growth stimulator and Marcaine pump for postoperative care. He was seen in the doctor's office approximately three weeks post surgery. He had his sutures removed, and a request was for x-ray at that time.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

Given the fact that this patient is already out of the hospital, and there is no possibility that the fusion could have progressed by that time, and that there were no complications or other indications necessitating additional x-rays, this request does not conform to the Official Disability Guidelines and Treatment Guidelines. For this reason, the previous adverse determination cannot be overturned. The reviewer finds that medical necessity does not exist for AP and lateral Lumbar X-Ray.

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
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- 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)