

# Becket Systems

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Apr/09/2010

**IRO CASE #:**

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

Cervical Spinal Cord Stimulator Trial

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

MD, Board Certified Orthopedic Surgeon  
Board Certified Spine Surgeon

**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**

Adverse Determinations, 1/22/10, 2/8/10

ODG Guidelines and Treatment Guidelines

Patient Chart Report 3/25/10

Imaging 9/20/08

Orthopedic Consultants 5/10/07

MPM 9/7/07, 11/19/09, 11/17/09

APRN, BC 10/5/07, 11/2/07, 11/30/07, 12/28/07

DO 9/2/08, 7/25/08, 11/24/09, 12/3/09, 12/17/09, 1/14/10, 2/11/10, 3/9/10

1/14/10, 12/23/09, 12/3/09

Orthopedics and Spine Associates 11/17/09

3/17/10

3/15/10

**PATIENT CLINICAL HISTORY SUMMARY**

This is an injured worker who, according to the medical records, has undergone a previous cervical fusion, two levels. Subsequent imaging studies and physical examination do not document any radiculopathy. There is, however, a tremendous amount of medications that are being prescribed, apparently with no benefit. There is note that the psychological evaluations are unequivocal as to suitability. There are no documented physical examinations nor objectification of the radicular complaints on imaging studies.

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

Given the absence of radicular complaints and the note that the psychological evaluations are unequivocal as to suitability, this patient does not conform to Official Disability Guidelines and Treatment Guidelines which are statutorily mandated in the State of Texas. It is for this reason that the previous adverse determination cannot be overturned. The request does not satisfy the ODG. The reviewer finds that medical necessity does not exist for Cervical Spinal Cord Stimulator Trial.

**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)