

# Becket Systems

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Apr/27/2010

**IRO CASE #:**

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

CT Scan with Reconstruction of the Lumbar Spine

**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**

ODG Guidelines and Treatment Guidelines  
Adverse Determination Letters, 3/10/10, 2/18/10, 3/9/10  
Preauth Request Form, 3/4/10  
MD, 1/15/10, 11/13/09, 8/18/09  
CT Scan of the Lumbar Spine Post Myelography, 12/5/08  
Operative Report, 7/27/09  
PT Progress Report, 1/4/10, 12/18/09, 12/28/09, 12/30/09  
Impairment Resources, 6/18/09  
MD, Designated Doctor Report, 2/27/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is an injured worker who, based on the medical records, initially underwent a lumbar fusion at L4/L5 which resulted in a pseudoarthrosis. The patient then underwent a subsequent reconstruction of the lumbar spine with a TLIF anterior approach in approximately 07/09. The patient complains of new leg pain. X-rays, 4 views, have been taken and are said to show resolution of a previous pseudoarthrosis. Current request is for a repeat CT scan with reconstruction.

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

Based on the medical records, the neurological examination is entirely normal. The records indicate this patient is exhibiting exaggerated pain behaviors. Based upon the x-ray reports, the physical examination is benign. The neurological examination is negative, and the x-rays show progression. Based upon what appears to be a successful surgery outcome and a satisfactory clinical outcome, the current request would be unlikely to lead to any change in the patient's outcome or plan of treatment. Since the treating physician has not explained why the Official Disability Guidelines and Treatment Guidelines should be set aside in this

particular case or why this particular request would conform to standard medical practice, this reviewer is unable to set aside the previous adverse determination. The reviewer finds that medical necessity does not exist for CT Scan with Reconstruction of the Lumbar Spine.

**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)