Becket Systems

An Independent Review Organization
815-A Brazos St #499
Austin, TX 78701
Phone: (512) 553-0360
Fax: (512) 366-9749
Email: manager@becketsystems.com

Review Outcome

Description of the service or services in dispute:

Trial dual XX XX XX with fluoroscopy under anesthesia. Due to XX will need anesthesia.

XX XX of XX XX, epidural, XX

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified PM&R

Board Certified Pain Medicine

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

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

Patient Clinical History (Summary)

XX. XX XX is a XX-year-old XX who was injured on XX. While XX a XX, a large XX of XX XX causing XX to injure XX XX, XX, and XX. XX was diagnosed with other XX XX XX in the unspecified XX region.

On XX, XX. XX was seen by XX. XX complained of XX XX, XX, XX, and XX pain, swelling, sensitivity, and burning that was worse than ever. XX had failed surgical intervention including XX XX release for work-related injury. Additionally, XX was suffering from chronic XX pain associated with XX radiculopathy. As a result, XX wanted to go ahead with a trial of XX XX XX. XX believed that XX. XX was an excellent candidate to try an outpatient trial for XX XX of XX persistent XX, XX, and XX pain. XX could barely turn XX XX to the XX. XX also had swelling in XX XX XX and XX consistent with the neuropathic pain process. XX use of XX and XX analgesics improved XX function during the trial period. XX had undergone appropriate XX clearance and major XX or personality XX had been ruled out. XX had decreased XX range of motion, mild-to-moderate XX XX tenderness, decreased XX strength on the XX, XX, pain with passive range of motion throughout XX XX XX and XX consistent with a double XX injury that included the XX XX failed surgery as well as XX XX surgery. XX affect had improved. XX XX continued to be moderate as XX stated that XX pain made XX “that way”. XX Centers for Epidemiological Studies XX Scale (XX) was 43/60 and general XX disorder (XX) test score was 19/20. On XX, XX. XX was seen by XX in a follow-up visit for double XX injury. XX had failed XX surgery with persistent XX radiculopathy as well as failed XX XX, all of XX work injuries were in XX. XX main complaint was continued severe XX pain, having failed surgical intervention including XX XX and persistent radiculopathy. XX had failed conservative rehabilitative medical treatment options. XX was requiring ongoing XX and XX analgesia allowing XX to be functional both at home and for activities of daily living as well as light work in the community. Due to persistent nature of XX pain for XX radiculopathy and post XX XX pain syndrome associated with secondary XX XX syndrome they recommended XX stimulation. The suffering from chronic neuropathic pain of which XX stimulation was indicated under the Official Disability Guidelines (ODG) and was of significant value reducing the use of XX and XX analgesia

was consistent with the XX Labor Code and with the wishes of the XX Medical Board, which supported intervention in lieu of reducing XX analgesia and concern.

A CT scan of the XX XX dated XX demonstrated congenitally-small XX XX XX, XX-mm posterior XX disc XX at XX-XX and XX-XX, which impinged upon the XX XX and the anterior surface of the XX XX XX causing mild XX XX XX XX at both segments, a XX-mm XX XX disc XX at XX-XX, a XX-mm XX XX disc XX at XX-XX, a XX-mm posterior XX XX XX at XX-XX, and moderate XX facet joint XX on the XX at XX-XX and XX-XX and XX at XX-XX.

The treatment to date included surgeries (XX XX and XX XX surgeries, XX XX release, anterior XX XX at XX-XX and XX-XX, and XX disc arthroplasty at XX-XX and XX-XX), XX sessions, XX therapy sessions, XX therapy sessions, XX days of chronic pain program, XX hours of functional restoration program, injections, and medications (XX, XX, XX, XX, and XX).

Per the utilization review decision letter dated XX by XX, the request for a trial of dual XX XX XX with fluoroscopy under anesthesia, XX medially was non-authorized. Rationale: “Upon chart review of the case, there was not sufficient documentation to support complex regional pain syndrome type I including documentation of what diagnostic criteria was used to diagnose complex regional pain syndrome (CRPS) type 1. Instead, the supporting documentation appeared to identify XX radiculopathy, XX post-XX syndrome, XX XX pathology, and double XX syndrome - XX radiculopathy and XX XX syndrome as the diagnosis for the injured worker’s symptoms. Therefore, the request for a trial of a dual XX XX XX with fluoroscopy under anesthesia, XX was not medically necessary and non-authorized.” Per the utilization review decision letter dated XX by XX, the request for a trial of dual XX XX XX with fluoroscopy under anesthesia, XX medially was non-certified. Rationale: “Per ODG XX guidelines, "Not recommended for any condition specific to the XX XX. "In the case, the pain was attributed to XX radiculopathy and "post XX XX pain syndrome." Those indications were not supported by ODG. It was noted that there was no CRPS diagnosis in the case. Therefore, the request for trial dual XX XX XX with fluoroscopy under anesthesia, XX was not medically necessary.”

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

Based on the clinical information provided, the request for Trial dual XX XX XX with fluoroscopy under anesthesia. Due to XX will need anesthesia. XX XX of XX XX, epidural, percutaneous is not recommended as medically necessary, and the previous denials are upheld. Per the utilization review decision letter dated XX by XX, the request for a trial of dual XX XX XX with fluoroscopy under anesthesia, XX medially was non-authorized. Rationale: “Upon chart review of the case, there was not sufficient documentation to support complex regional pain syndrome type I including documentation of what diagnostic criteria was used to diagnose complex regional pain syndrome (CRPS) type 1. Instead, the supporting documentation appeared to identify XX radiculopathy, XX post-XX syndrome, XX XX pathology, and double XX syndrome - XX radiculopathy and XX XX syndrome as the diagnosis for the injured worker’s symptoms. Therefore, the request for a trial of a dual XX XX XX with fluoroscopy under anesthesia, XX was not medically necessary and non-authorized.” Per the utilization review decision letter dated XX by XX, the request for a trial of dual XX XX XX with fluoroscopy under anesthesia, XX medially was non-certified. Rationale: “Per ODG XX guidelines, "Not recommended for any condition specific to the XX XX. "In the case, the pain was attributed to XX radiculopathy and "post XX XX pain syndrome." Those indications were not supported by ODG. It was noted that there was no CRPS diagnosis in the case. Therefore, the request for trial dual XX XX stimulator with fluoroscopy under anesthesia, XX was not medically necessary.” There is insufficient information to support a change in determination, and the previous non-certification is upheld. The submitted clinical records fail to establish that this patient presents with a condition for which the Official Disability Guidelines would support a XX XX stimulator. The Official Disability Guidelines note that XX XX XX are not recommended for any condition specific to the XX XX. There is no documentation of any recent active treatment. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

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
- ☐ 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)

Appeal Information

You have the XX 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.