SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
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Notice of Independent Review Decision

DATE OF REVIEW: August 20, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CT scan of the lumbar spine

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

Diplomate, American Board of Orthopaedic 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

Medical records from the Carrier include:

- Hospital, 3/8/00

- M.D., 1/17/02
- Orthopedic Center, 10/5/04, 1/25/05, 5/5/05, 1/13/06, 5/16/06, 7/18/06, 11/14/06, 3/13/07
- M.D., 4/8/05, 4/16/07
- Hospital, 4/21/05, 6/13/05

Medical records from the Requestor include:

- M.D., 5/4/94, 12/6/94, 2/13/95, 4/6/95, 6/5/95, 8/17/95, 10/5/95, 12/6/95, 1/30/96, 5/28/96, 8/5/96, 9/4/96, 10/15/96, 12/11/96, 4/8/97, 6/4/97, 8/4/97, 9/23/97, 11/19/97, 1/20/98, 3/18/98, 5/14/98, 7/22/98, 9/17/98, 10/7/98, 11/12/98, 12/31/98, 3/25/99, 5/18/99, 6/30/99, 12/23/99, 1/31/00, 3/3/00, 3/29/00, 4/20/00, 5/2/00, 6/27/00, 9/19/00, 12/7/00, 3/15/01, 6/19/01, 9/18/01, 11/20/01, 1/31/02, 3/28/02, 5/22/02, 7/23/02, 9/24/02, 11/26/02, 1/21/03, 7/15/03, 10/21/03, 6/8/04, 1/25/05
- Center, 5/4/94
- MRI Center, 8/1/94
- M.D., 8/24/94
- Orthopedic Center & Medicine, 9/22/94, 12/6/94, 2/9/95, 12/6/95
- Orthopedic Center, 2/17/98, 3/24/98, 4/24/98, 9/10/99, 5/5/05, 6/7/05, 6/24/05, 7/5/05, 7/15/05, 9/15/05, 1/31/06, 5/16/06, 7/18/06, 11/14/06, 3/13/07
- Center, PA, 3/17/98, 9/16/98, 12/31/98, 3/25/99, 6/30/99, 3/1/00,
- CT Scan Center, 9/14/98
- D.O., 9/10/99
- Hospital, Inc., 3/9/00
- Hospital, 3/8/00
- Associates – 1/17/02
- Rehabilitation Institute, 12/10/02, 1/7/03, 2/25/03, 3/18/03, 4/8/03,
- Center for Pain & Stress Management, 1/10/03
- Hospital, 4/21/05, 6/13/05

PATIENT CLINICAL HISTORY:

The records indicate a long history of lower back problems. The patient underwent surgery in 1988 initially. He subsequently had revision surgery. He was placed at maximum medical improvement in 1994. On March 8, 2000, he underwent lumbar laminectomy and spinal fusion at L5-S1 with instrumentation and iliac crest bone grafting. In April 2005, a CT scan was performed disclosing a solid fusion at L5-S1. On June 13, 2005, the patient underwent removal of hardware with reinforcement of the spinal fusion. This reinforcement was explained in the operative report that bone graft was taken from the bone bank and sewed into the wound.

The patient continued to see Dr. postoperatively. He did develop a hematoma postop following that surgery. The patient eventually healed from the hematoma. He continued to follow with Dr. In January 2006, he was doing better although he continued having pain. In May of 2006, the patient continued reporting severe back pain with changes in the weather. On March 13, 2007, the patient continued complaining of low back pain. At that time Dr. recommended repeat CT scan to determine status of the fusion. No x-rays were obtained. No other records are provided.

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

It is my opinion that a repeat CT scan is not indicated. A repeat CT scan does not currently meet ODG Guidelines. Additionally, Dr. has not had plain films taken. Given no intervening trauma and no new physical findings, it is my opinion that a repeat CT scan is not justified and does not meet ODG Guidelines.

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**
- ☐ **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)**