

IRO Express Inc.

835 E. Lamar Blvd. #394

Phone: 817-235-1979

Fax: 817-5489-0310

DATE OF REVIEW: JUNE 2, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

1. Is repeat cervical CT with contrast medically necessary?
2. Is cervical CAT scan with reconstruction medically necessary?

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

Board Certified Orthopedic 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Cervical spine MRI, 05/10/06
Operative report, 07/28/06
Post discogram CT scan, 07/28/06
Office note, Dr., 11/15/06
Office notes, Dr., 12/05/06, 02/28/07 and 04/25/07
Pre-authorization form, 02/13/07
Peer review, Dr., 02/16/07
Pre-authorization determination letter, 02/16/07
DDE, Dr., 04/04/07
Report summary, 04/04/07
MRI lumbar spine, Dr., 03/27/06
MRI lumbar spine, Dr., 03/27/06
Office visit, Dr., 01/25/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male whose history is significant for a discectomy around xxxx; two lumbar laminectomies, xxxx and xxxx; lumbar laminectomy and three level fusion in xxxx; revision of previous lumbar fusion from L4-S1 with extension of fusion from L3-4 in xxxx.

On xx/xx/xx he was carrying about 25 pounds of surgical equipment, tripped over a spray to a machine, fell sideways hitting the wall with his head and left side of his body, then fell to the floor landing on his left knee. He reportedly did not lose consciousness and got up and continued working. He was diagnosed with cervical disc herniations at C5-6 and C6-7, cervical radiculitis/radiculalgia and cervical myofascial pain disorder. On 11/21/06 he underwent an anterior cervical discectomy and fusion of C5-7. He did well for the first four weeks, but developed problems with the adjacent levels above and below the fusions. A cervical CT with contrast was recommended, but denied by Dr. on 02/16/07 stating that CT scans were only recommended for trauma patients. Dr. again recommended the CAT scan on 02/28/07.

Dr. performed a Designated Doctor Evaluation on 04/04/07 and stated that on 02/12/07 Dr. noted that other physicians had requested further testing and possibly more cervical surgery, however he recommended weight loss, exercise, medication detoxification and work hardening, which were not carried out. The claimant reported frequent falling even with the use of a cane and/or walker, urinary frequency and dribbling and erectile dysfunction, severe daily headaches with minimal visual disturbances and depression. Dr. felt that the claimant was unable to return to work in any capacity and recommended a functional capacity evaluation, MRI and CT scans as previously recommended and the surgery indicated per those studies.

Dr. saw the claimant on 04/25/07 requesting CT/myelogram of C3-4 and C4-5.

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

Based on the information above, it would appear that Dr. is requesting a CT scan with myelogram in this case. Indeed, a CT scan with myelogram is an excellent study to detect nerve root compression from herniated discs. It can also very nicely access foraminal stenosis and central stenosis from a degenerative process such as osteophyte formation and facet degeneration.

However, there is no good documentation in this case of any plain film evidence of a progressive degenerative process or instability. There is no good documentation of radiculopathic or myelopathic findings to suggest the need for this evaluation. Clearly there were degenerative discs at the levels above the previous fusion for the fusion. However, there has not been any clear

documentation of any additional problem in the form of an objective clinical finding or objective radiographic finding which would allow the Reviewer to suggest that the requested CT scan is medically necessary at this time. Further documentation of physical findings to suggest some correctable problem would be needed before simply authorizing further imaging of known degenerative levels above a previous fusion. Therefore, the previous adverse determination would be upheld.

Official Disability Guidelines, Fifth Edition, 2007, Neck and Upper Back Chapter, Computed Tomography (CT).

Not recommended except for indications below. **Indications for imaging -- CT (computed tomography):**

- Suspected cervical spine trauma, alert, cervical tenderness, paresthesias in hands or feet
- Suspected cervical spine trauma, unconscious
- Suspected cervical spine trauma, impaired sensorium (including alcohol and/or drugs)
- Known cervical spine trauma: severe pain, normal plain films, no neurological deficit
- Known cervical spine trauma: equivocal or positive plain films, no neurological deficit
- Known cervical spine trauma: equivocal or positive plain films with neurological deficit

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
 - Official Disability Guidelines, Fifth Edition, 2007, Neck and Upper Back Chapter, Computed Tomography (CT).
- 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)