True Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: August 15, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Outpatient bone scan single photon emission computed tomography (SPECT) to evaluate for pseudoarthrosis in the thoracic region of the scoliosis fusion.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
UR Reviews, 07/23/08, 07/30/08
Office notes, Dr. 12/21/05, 01/17/06, 02/28/06, 04/121/06, 07/31/06, 04/20/06, 10/31/07, 11/29/07, 03/22/07, 01/21/08
Office note, Dr. 02/21/08
Office note, Dr. 02/29/08
Office note, Dr. 07/09/08
Record review, Dr. 04/18/05
Designated medical examination, Dr. 01/20/02
Required Medical Examination, Dr. 03/05/03
Operative reports, 01/09/06, 04/20/06, 11/05/07, 01/07/08, 03/13/08
Discharge summary, 03/14/08
MRI cervical, 02/28/06
X-rays thoracic spine, 01/07/08, 03/22/08

X-rays lumbar, 10/24/05, 06/10/08
CT head, 03/14/08
Physical therapy records, 10/18/06, 05/13/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This female claimant reportedly sustained a low back injury in xxxx. The records indicated that since that time the claimant has undergone lumbar surgeries in 1972, 1974 and 2002 and was subsequently diagnosed with chronic pain syndrome and lumbar radiculitis. The claimant had undergone dorsal column spinal cord implantation with several replacement and revision surgeries. A 07/09/08 physician visit revealed the claimant with primary thoracic pain, low back pain and bilateral lower extremity pain. An examination revealed spine tenderness, a positive straight leg raise bilaterally, hyperesthesia over the left L3 nerve root distribution and pressure over the left S1 nerve root distribution. According to the records, the treating physician was concerned about a possible breaking of the fusion at the level of the thoracic laminotomy. A bone (SPECT) scan was recommended to evaluate for a pseudoarthrosis in the thoracic region of the scoliosis fusion. Flexion and extension x-rays were also recommended.

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

This claimant sustained a back injury in xxxx. The records indicate she underwent multiple surgical procedures. The concern is of possible pseudoarthrosis. She has had chronic pain. She has also undergone a dorsal column stimulator. Examination revealed tenderness. The treating physician was concerned of a possible pseudoarthrosis or breakage of the fusion. Thus, recommendations were for a bone scan with SPECT imaging.

This would be approved due to her clearly chronic history of back pain and prior surgery. It may help determine if there is in fact a pseudoarthrosis or difficulty with the fusion.

Official Disability Guidelines state that bone scans are used for bone infections, cancer and arthritis. This reviewer would state those bone scans are very sensitive for increased bone metabolic activity but highly nonspecific. For a stress fracture such as a spondylolysis, they are very beneficial. A fractured fusion or pseudoarthrosis would be very similar. As an orthopedic surgeon, I would agree with the bone scan to rule out any evidence of a pseudoarthrosis or fracture of the fusion accounting for her pain.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates,
Low Back: Bone scan. SPECT (single photon emission computed tomography).

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)**