



DATE OF REVIEW: 09/06/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar CT scan.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

D.C., practicing sixteen years, currently practicing chiropractic and rehabilitative therapy

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

The request for CT scan of the lumbar spine submitted previously by Peer Review on 06/12/08 and 08/04/08 does not meet the criteria for medical necessity. There is no objective medical evidence submitted to document neurological deficit or any change in the patient’s condition. While the injured employee still complains of symptomatology of low back and bilateral leg pain, prior studies have not revealed neural foraminal compromise, nerve root compression, or spinal cord impingement. Due to the specificity of the ODG Guidelines regarding the use of CT scan and the lack of new exam findings, the criteria for medical necessity has not been met.

INFORMATION PROVIDED FOR REVIEW:

1. 08/19/08, fax cover to for lumbar CT scan
2. 08/18/08, fax cover from to , IRO request, two pages
3. 08/18/08, confirmation of receipt of request for IRO
4. 08/18/08, company request for IRO, six pages
5. 08/18/08, typewritten note from , reference preauthorization denial
6. 04/07/08, preauthorization denial for CT myelogram, lumbar, three pages
7. 06/12/08, preauthorization denial, repeat lumbar CT scan and bilateral lower extremity EMG/NCV, four pages
8. 08/04/08, preauthorization denial, lumbar CT scan, four pages

9. 08/19/08, notice of case assignment to
10. 08/11/08, request for lumbar CT scan to be presented for , four pages
11. 05/29/08, 06/06/08, 08/15/08, and 08/21/08, prescription for lumbar spine CT scan and L-spine series x-rays at DMI, multiple dates per the fax date stamps at the top of the page
12. 07/23/08, preauthorization request for a CT scan of the lumbar spine, reconsideration, three pages
13. 03/31/08, handwritten initial exam, copy illegible; there were two copies included in the documents for review, both unreadable

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The injured employee was using a power washer on xx/xx/xx when it fell on his right leg. He subsequently developed low back pain and bilateral radicular lower extremity pain. The injured employee had MRI scan, CT myelogram, and EMG/NCV study. Mild bulges were noted at L4, L5, and S1. Records indicate that surgery was recommended and denied. Injured employee did have injection therapy and rhizotomy. The CT scan was requested and denied on 06/12/08. It was appealed and again denied on 08/04/08, resulting in the request for dispute resolution.

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

This review was for a decision on a request of lumbar CT scan. The injured employee has a history of low back and bilateral leg pain since his xx/xx/xx injury. The MRI scan, EMG/NCV study, and CT myelogram were performed. No neurological compromise was indicated in any of the documentation presented for review. No new exam data was submitted for review other than an initial exam dated 03/31/08, which was unreadable, perhaps due to having been faxed several times. However, it was illegible. The ODG is clear as to rationale for CT scan, and this injured employee does not have any new objective findings that would indicate a progression of disease or neurological compromise. This testing cannot be authorized with the limited information provided for review.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

(Check any of the following that were used in the course of your review.)

- 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)