Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 1/25/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The service under dispute is a CT scan of the lumbar spine.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewing physician is a board certified Medical Doctor who is board certified in Physical Medicine and Rehabilitation.

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)

The reviewer disagrees with the previous adverse determination regarding all services under review.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties:
and Dr. .

These records consist of the following (duplicate records are only listed from one source):
: 1/6/09 letter from , MD, LHL009 form with attachments, 12/19/08 request for lumbar CT letter by Dr. with a script, 11/10/08 denial letter, 11/10/08 email from Dr. , 11/6/08 email from , 11/4/08 preauth request, 12/1/08 denial letter, 12/1/08 email from , 11/24/08 email from , 11/17/08 preauth request for , 11/6/08 email from , patient file data sheet, 11/6/08 and 1/2/09 emails from , 8/8/07 radiology reports of right hip xrays, cervical CT, abdominal/pelvic CT, chest CT and head CT. daily notes by Dr. from 8/20/07 to 10/23/08 (there is reference at the top of this page to a visit on 8/17/07; however, the report is not present), 10/19/07

report of MMI with DWC 69, 4/10/08 lumbar MRI, 11/7/08 neurodiagnostic testing, 8/24/07 PPE #1 and progress report of 9/19/07 by .

Dr. : no additional records were received from the doctors office that were not already included in the carrier's submission.

We did not receive a copy of the ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:
This gentleman was injured on xx/xx/xx while on the job. He sustained injuries to his skull and spine. He was hit by a backhoe which slammed him into a cement pipe. A lumbar MRI in April of 2008 was significant for T11-12 spinal stenosis, L4/5 DDD with protrusion into the right neural foramen yielding impingement on the right L4 nerve root. An EMG/NCS by Dr. on 11/7/08 was consistent with right L4/L5 radiculopathy. His clinical examination is consistent with dural irritation.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
The indications for a lumbar CT scan are as follows from the ODG:

- Lumbar spine trauma: trauma, neurological deficit (this criterion is met as he sustained trauma to the lumbar spine from the work related accident and there is clinical and electrical evidence of neurological deficits.

- Lumbar spine trauma: seat belt (chance) fracture (this does not apply in this case)

- Evaluate pars defect not identified on plain x-rays (it is possible that a pars defect could be missed by the MRI and a lumbar radiograph; therefore, a CT may be beneficial to evaluate a possible osseous defect in the posterior spinal elements)

- Evaluate successful fusion if plain x-rays do not confirm fusion (not applicable in this case)

Based upon the above-listed information and the reviewer's professional judgment, the requested service is medically necessary at this time based upon the records presented by all parties and the ODG.

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)**