

C-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/29/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient CT of the lumbar spine without contrast and MRI of the lumbar spine with and without contrast.

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

M.D., board certified in Orthopedic 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

1. Adverse Determination letters, 06/18/09, 07/10/09
2. , 07/17/09
3. Dr. , 03/15/06, 04/01/09, 05/03/06, 05/04/09, 06/26/09, 01/11/06, 08/24/05
4. Lumbar spine, three views, status post fusion, 04/11/06
5. Radiology report, 11/10/05
6. Discharge summary, 05/26/05
7. Surgical pathology report, 05/23/05
8. MRI scan of lumbar spine, 02/24/03
9. ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is a claimant who injured his back in a slip-and-fall accident in xxxx. He underwent a lumbar fusion and decompression at L4/L5 on 06/06/05. He has x-rays post surgery which show the pedicle screws are in good position and he has a grade 1 spondylolisthesis of L5 on S1, which is stabilized by instrumentation. He apparently now complains of low back pain. It is specifically documented that there is no leg pain. Current diagnosis is status post lumbar fusion with back pain. Request is for CT scan and MRI scan with and without contrast.

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

As previous reviewers have noted, without any progressive neurological deficit, this claimant

does not meet ODG criteria for the requested studies. There is no evidence of pseudoarthrosis or other findings that would merit a CT scan and no evidence of progressive neurologic deficit that would merit the MRI scan with and without contrast. The requested physician has failed to give an explanation within the records provided as to why these studies are being requested and why Official Disability Guidelines and Treatment Guidelines should be set aside in this particular case. It is for this reason that the previous adverse determination cannot be overturned. The reviewer finds that medical necessity does not exist for Outpatient CT of the lumbar spine without contrast and MRI of the lumbar spine with and without contrast.

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

- ACOEM-AMERICA 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)