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An Independent Review Organization
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DATE OF REVIEW:

Jun/03/2009

IRO CASE #:**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Lumbar CT 72132

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

M.D., 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

ODG Guidelines and Treatment Guidelines

MRI Lumbar Spine: 06/27/08

Dr.: 08/15/08

-- licensed psychologist: 10/09/08

Dr. 11/13/08

Dr. Office Notes, Plain Lumbar X-Rays and Prescription for Lumbar Discogram: 03/31/09

Authorization Request: 04/06/09

Determination Letters, 04/10/09 & 04/16/09

PATIENT CLINICAL HISTORY SUMMARY

This female sustained an injury to her low back on xx-xx-xx while moving boxes. A diagnosis of lumbosacral intervertebral disc disease and acquired/degenerative spondylolisthesis was documented. A lumbar MRI dated 06/27/08 was reviewed to reveal moderate multilevel degenerative changes with mild to moderate degenerative disc disease and posterior disc bulges at L3-4 and L4-5 levels with effacement of anterior thecal sac and minimal encroachment of the left neural foramen at the L4-5 level. The claimant was examined by Dr. on 03/31/09 following a 9 month history of continued low back and leg pain which had failed to improve with conservative measures including physical therapy, medications, and chiropractic. Documentation revealed the claimant was unable to undergo lumbar epidural steroid injections due to allergies. Objective exam findings included restricted and painful lumbar range of motion and mild deficits in the tibialis anterior and extensor hallucis longus bilaterally which was greater on the right. Plain x-rays of the lumbar spine taken on 03/31/09 revealed evidence of degenerative spondylolisthesis at L3-4 and L4-5 segments and a psychological assessment performed on 10/09/08 cleared the claimant to proceed with proposed discography and spinal surgery. Dr requested authorization to proceed with a

lumbar CT scan following a proposed lumbar discogram at L3-4 and L4-5 with controls to be done at L2-3 and L5-S1. This review is to determine the medical necessity for the lumbar CT scan.

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

The requested CT scan is not medically necessary based on review of this medical record. This is a woman who has degenerative disc disease of the lumbar spine with recurrent onset of pain in xxxx. She has undergone an MRI documenting degenerative disc disease of the lumbar spine but she has also undergone flexion/extension stress lateral x-rays that do not show structural laxity or instability to the level that would rise to the need for surgery. She has been treated conservatively and continues to have pain and her physician has requested lumbar discogram and post CT scan to try and determine her painful disc segments prior to initiating fusion surgery. CT discogram tests are done to try and determine a specific disc level of pain, however there are no good studies in the literature documenting the use of a CT discogram to determine whether or not a patient will in fact have improvement or recovery following disc fusion surgery. ODG guidelines discuss the use of discogram and indicate that it is not recommended. Since there is no medical necessity for the discogram, then the post discogram CT scan to evaluate the morphology of the discs after the dye has been injected is also not medically necessary. The request does not meet the guidelines. The reviewer finds that medical necessity does not exist for Lumbar CT 72132.

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)