

# C-IRO Inc.

An Independent Review Organization  
7301 RANCH RD 620 N, STE 155-199A  
Austin, TX 78726  
Phone: (512) 772-4390  
Fax: (512) 519-7098  
Email: resolutions.manager@ciro-site.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jan/11/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** THORACIC MRI WITH AND WITHOUT CONTRAST

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

1. Adverse Determination letters, 10/26/09, 11/24/09
2. M.D., 11/08/09, 10/14/09
3. Medical Center, 08/12/08, 06/13/08
4. M.D., 07/27/09
5. M.D., 10/23/09
6. ODG Guidelines and Treatment Guidelines

**PATIENT CLINICAL HISTORY SUMMARY**

This is an injured worker who was originally injured on xx/xx/xx. He underwent a lumbar fusion in the past at L4/L5 as well as at L1/L2. Lumbar x-rays and CT scan were performed in 2008 and reveal spondylitic defects of the fusion at L3 and L1. There is no explanation within the medical record as to why the physician is requesting a thoracic MRI with and without contrast.

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

There is no information within the medical records that explains why the current treating physician is requesting a thoracic MRI scan. In fact, in the medical records that were provided, there appears to be no discussion concerning the thoracic spine. The previous reviewer notes that the records do not contain any physical therapy progress notes or indicate a progressive neurological deficit attributable to thoracic pathology. With this gap between the request and the medical records, this reviewer is unable to overturn the previous adverse determination. There is little neurological information available, and other than the fact there are complaints of pain, there is little for this reviewer to go on that would permit the ODG Guidelines to be set aside. It is for these reasons that the previous adverse determination cannot be overturned. The reviewer finds that medical necessity does not exist

at this time for Thoracic MRI 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)