

# I-Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Nov/04/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

CT Scan Lumbar Spine L1-S1

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

MD, Board Certified Orthopedic Surgeon  
Board Certified Spine 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  
Adverse Determination Letters, Inc. 10/4/10, 10/13/10  
M.D. 10/4/10, 9/15/10  
M.D. 5/24/10  
Medical 6/1/10, 5/24/10  
Surgicare 7/15/08

**PATIENT CLINICAL HISTORY SUMMARY**

This is an injured worker who, according to history, sustained a burst fracture of L1 and underwent an instrumented fusion, corpectomy, and instillation of a cage. There is question of solid fusion, and there is question of displacement of the implant. Current request is for a CT scan of the lumbar spine.

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

Given the patient's previous surgical history and traumatic history and the plain bone films not revealing solid fusion based upon the records, it is medically necessary that this fact be substantiated due to the potential for serious neurological deficit if the fusion is not solid. The

patient, according to the record, underwent corpectomy at L1 with a reconstruction of T12 to L3 and a T10 to L3 posterior fusion subsequently. The ODG Guidelines recognize that if plain bone films do not identify the fusion, and if the patient is the subject of significant trauma, CT scan is an appropriate evaluative procedure. This particular request does conform to the ODG Guidelines and is reasonable under those guidelines and under guidelines of the usual criteria of medical judgment and experience. The reviewer finds that medical necessity exists for CT Scan Lumbar Spine L1-S1.

**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)