SENT VIA EMAIL OR FAX ON
Oct/08/2010

True Decisions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (214) 717-4260
Fax: (214) 594-8608
Email: rm@truedecisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Oct/08/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Thoracic CT/Myeolgram; Lumbar CT/Myeolgram

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

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[ ] Upheld (Agree)

[X] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
MRI Lumbar 01/29/10
MRI thoracic w/3D 02/02/10
Dr. office note 07/02/10
Dr. office note 07/08/10

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a male who developed back pain while lifting a heavy toolbox on xx/xx/xx. The initial diagnosis was not indicated. A lumbar MRI on 01/29/10 revealed a possible disc herniation at T12-L1 noted on sagittal images. Dedicated MR imaging of the thoracic spine was recommended. A thoracic MRI on 02/02/10 revealed a left central disc herniation at T12/L1 measuring approximate 4-5 millimeters. Contact with the anterior aspect of the distal spinal cord was demonstrated. There was a possible disc herniation at C5-6.

Dr. saw the claimant on 07/02/10 stating that Dr. did not recommend surgery. The claimant

wanted another opinion with another spine surgeon. He indicated his thoracic symptoms had decreased. He reported decreased motion. He indicated his lumbar pain had decreased and was had decreased lumbar motion and decreased lumbar weakness.

Examination of the thoracic spine showed decreased flexion and decreased muscle spasm. The lumbar exam showed restricted motion in all planes. Sitting and supine straight leg raises were positive bilaterally. Bilateral thoracic and lumbar sprain/strain were diagnosed. Robaxin, Ultracet, restricted duty and referral to a spine surgeon were recommended.

Dr. saw the claimant on 07/08/10 for back pain radiating to both legs. His pain was intermittent and associated with numbness/tingling and stiffness. He had therapy without improvement and an epidural steroid injection. There was decreased lumbar flexion and extension with pain, normal and symmetrical reflexes bilaterally, normal sensation, a positive straight leg raise on the left and pain with straight leg raise that radiates from the back to the ankle. He had no weakness. There was tightness in the bilateral hamstrings. T12/L1 4 millimeter left herniated nucleus pulposus was diagnosed. A myelogram/CT T8-S1, Naprelan, Ultracet, Robaxin and Lyrica were recommended. Dr. did not feel surgery would help.

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

Based solely on records reviewed, evidenced based medicine, the approved CT myelogram and lumbar CT is medically necessary as a diagnostic modality to further assess the findings on MRI of 01/29/10 and 02/02/10 by reported injury, subjective complaints of pain and perceived disability associated with reported injury xx/x/xxx with the symptoms that the patient offered to Dr. and Dr..

Based solely on records reviewed, evidenced based medicine, and the IRO reviewer's experience as a board certified orthopedic surgeon, this patient had a reported traumatic injury of xx/xx/xxand with a positive MRI and reported radicular symptoms, which are persistent despite exhaustive conservative to include PT/OT, epidural steroid injections and pain medications, muscle relaxants.

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, (i.e. Low Back-CT and CT Myelography)

Not recommended except for indications below for CT. CT Myelography OK if MRI unavailable, contraindicated (e.g. metallic foreign body), or inconclusive

<u>Indications for imaging</u> -- Computed tomography:

- Thoracic spine trauma: equivocal or positive plain films, no neurological deficit

- Thoracic spine trauma: with neurological deficit

- Lumbar spine trauma: trauma, neurological deficit

- Lumbar spine trauma: seat belt (chance) fracture

- Myelopathy (neurological deficit related to the spinal cord), traumatic

- Myelopathy, infectious disease patient

- Evaluate pars defect not identified on plain x-rays
- Evaluate successful fusion if plain x-rays do not confirm fusion

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)