

# Clear Resolutions Inc.

An Independent Review Organization  
6800 W. Gate Blvd., #132-323  
Austin, TX 78745  
Phone: (512) 879-6370  
Fax: (512) 519-7316  
Email: resolutions.manager@cri-iro.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** July 13, 2011

**IRO CASE #:**

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

X-ray 5-views of Lumbar spine

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

MD, BOARD CERTIFIED IN PHYSICAL MEDICINE & REHABILITATION

**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**

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male whose is reported to have a date of injury of xx/xx/xx. The claimant has a history of 4 lumbar surgeries. The claimant has a history of valvular heart disease and is status post a porcine valve replacement in 2006. On 06/02/11 the claimant was seen in follow-up. He is reported to have increasing axial back pain. The claimant believes he requires repeat facet rhizotomy. Most recent lumbar imagery is reported to have been performed in 2003. he injured employee has not had an MRI since 2003. On physical examination gait is normal. Motor strength is 4/5 bilateral ankle dorsiflexion, otherwise 5/5. Sensation is intact. Reflexes were absent at the knees and ankles. Sitting straight leg raise and Patrick's test were negative bilaterally. A well healed surgical scar was noted. There is some tenderness over the lumbar paraspinal musculature bilaterally. The claimant was referred for CT scan and x-rays of the lumbar spine. A utilization review was performed by Dr. on 06/08/11. Dr. non certified the request. She reports the claimant has had back pain for years post-op with no new findings. This had been successfully treated with lumbar radiofrequency. The injured employee was claiming pain was the same and wants radiofrequency now. It was noted there was no indication of new trauma or overall change in condition or suspicion of spinal instability to support the request. Without

any indication of acute change in condition the request for updated studies was not supported as medically necessary. An appeal request was reviewed by Dr. on 06/21/11. He opines that the reconsideration/appeal request for x-rays of the lumbar spine and CT scan was not medically necessary. He opines there is lack of clinical and historical data. He reports that there is no information to establish a progressive neurological deficit to warrant new/repeat imaging studies.

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

Based on the clinical notes provided, the request for X-ray 5-views of Lumbar spine is not recommended as medically necessary. The claimant was injured in xxxx. He is status post multiple lumbar surgeries including anterior fusion. Prior to undergoing open-heart surgery which included placement of pace maker, the claimant had obtained significant benefit from rhizotomy. After he was given a pacemaker rhizotomies could not longer be performed. However, it appears the claimant was managed effectively with facet / medial branch blocks. Based on the ODG Low Back Chapter, radiography is not recommended in the absence of red flags. There is no new trauma. There is no change in his condition. There is no suspicion of spinal instability. There are no other indications for imaging as defined in ODG. Therefore, upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

**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)