

SENT VIA EMAIL OR FAX ON
May/03/2011

Pure Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/03/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 CT scan of the lumbar spine without contrast

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

Texas Licensed DO, Board Certified Neurosurgery

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

OD Guidelines

1. UR determination letter 02/22/11 regarding non-certification reconsideration request of CT of lumbar spine without contrast
2. Utilization review determination 02/14/11 regarding non-certification request of CT of lumbar spine without contrast
3. Physician's advisor review regarding CT scan lumbar spine without contrast 02/21/11 M.D.
4. Physician's advisor review regarding CT scan of lumbar spine without contrast 02/11/11 M.D.
5. Request for treatment authorization form and appeal
6. Clinic notes M.D. 10/01/09-02/01/11
7. Operative report 02/01/10 regarding L5-S1 discectomy with bilateral medial facetectomies and foraminotomies, L5-S1 transforaminal interbody fusion with PEEK cage and autologous bone graft, and L5-S1 transverse process fusion with autologous bone graft and L5-S1 pedicle screw and rod fixation
8. Radiographic report chest x-ray 01/26/10
9. Radiographic report 02/01/10 intraoperative lateral view lumbar spine
10. Radiographic report 02/18/10 x-ray lumbar spine
11. Radiographic report 03/25/10 x-ray lumbar spine
12. Radiographic report 07/27/10 x-ray lumbar spine
13. Radiographic report 01/06/11 x-ray lumbar spine
14. MRI lumbar spine with and without contrast 08/13/10
15. Functional capacity evaluation 01/13/11
16. Designated doctor evaluation 07/20/10 M.D.

17. Electromyogram and nerve conduction study report 08/24/10
18. Physical therapy lumbar spine initial evaluation and reevaluation reports 04/01/10-08/11/10
19. Billing statement 08/13/10
20. Radiology orders MRI lumbar spine 08/13/10
21. Utilization review determination

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a male whose date of injury is xx/xx/xx. The injured employee is status post L5-S1 fusion performed 02/01/10 followed by postoperative physical therapy. The injured employee was doing well following surgery. Clinic note dated 07/27/10 noted the injured employee reported over the past few months he has had frequent episodes of his left leg going weak under him with episodic falling. The injured employee was referred for EMG/NCV which showed no evidence of acute nerve root injury or peripheral neuropathy, with evidence of bilateral chronic denervation of L5-S1 innervated muscles. This is consistent with prior injury. Repeat MRI scan done on 08/13/10 revealed postoperative changes with a 5 mm right paracentral disc protrusion at L2-3. There were mild degenerative changes at L4-5 with no significant stenosis or nerve root impingement. The L5-S1 level showed posterior fusion with metallic instrumentation and anterior interbody fusion. Clinic note dated 01/06/11 reported the claimant to be 11 months status post L5-S1 discectomy and fusion doing reasonably well. The injured employee has some minor degenerative low back pain symptoms but no significant leg pain symptoms. He is reported to have loss a considerable amount of weight. X-rays were noted to show good left intertransverse fusion mass, but the right side was obscured by instrumentation. It appeared the injured employee was ready to be released to return to work. The injured employee was referred for functional capacity evaluation. The injured employee was seen on 02/01/11 to review outcome of functional capacity evaluation. The injured employee was found to be able to function at light physical demand level. The injured employee was released to work with appropriate restrictions. Follow-up CT scan was recommended to assess fusion.

A request for CT scan of lumbar spine without contrast was reviewed by Dr. on 02/11/11. Dr. noted the injured employee has undergone L5-S1 discectomy with transforaminal interbody fusion with cage and transverse process fusion and L5-S1 pedicle screw and rod fixation performed 02/01/10. Lumbar MRI dated 08/13/10 was noted to clearly delineate presence of right paracentral disc protrusion at L2-3 and 3 mm retrolisthesis of L4 on L5. The latest medical records dated 02/01/11 did not include findings suggestive of progressive neurologic deficits that would warrant repeat imaging in form of CT scan. It was further noted that there is no evidence the injured employee has infection. Lastly, there was no documentation of failed conservative treatment because official serial and physical therapy reports were not submitted for review.

A reconsideration / appeal request for CT scan of lumbar spine without contrast was reviewed by Dr. on 02/21/11. Dr. determined the request to be non-certified as medically necessary. Dr. noted lack of documentation of progressive neurologic deficits, infection, and failed conservative treatments. On physical examination there were deficits in lumbar range of motion and pain while performing tasks in the functional capacity evaluation dated 01/31/11. Treatment was noted to include physical therapy; however, there is no documentation of diagnosis / condition for which CT is indicated.

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

The proposed CT scan of lumbar spine without contrast is indicated as medically necessary. The injured employee is status post anterior and posterior L5-S1 fusion performed 02/01/10. The injured employee was noted to have done reasonably well, but continued with some complaints. The most recent x-ray report dated 01/06/11 reported postoperative changes with fixation device apparently in good position. There is handwritten note from radiologist stating he cannot tell the status of interbody and posterolateral fusions at L5-S1 level, and recommends CT scan of lumbar spine with reformatted images to further evaluate. Per ODG guidelines, CT scan is indicated to evaluate successful fusion if plain x-rays do not confirm

fusion. Noting the most recent plain radiographs do not confirm successful fusion, CT scan is appropriate to further assess fusion mass.

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)