



14785 Preston Road, Suite 550 | Dallas, Texas 75254
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Notice of Independent Review Decision

DATE OF REVIEW: 6/11/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

OUTPATIENT CT SCANS OF THE LUMBAR AND CERVICAL SPINES.

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

M.D. Board Certified in Occupational Medicine/ Urgent Care.

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

Document Type	Date(s) - Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	5/22/2012
Notice of Utilization Review Findings	5/01/2012-5/09/2012
M.D. Office Visit Notes	2/13/2012-4/23/2012
Appeal Letter	5/02/2012
Community Center Imaging Report	1/19/2012

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a worker with neck and low back pain associated with an xx/xx/xx industrial motor vehicle accident.



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Thus far, he has been treated with the following: Analgesic medications, adjuvant medications; unspecified amounts of physical therapy; MRIs of the cervical and lumbar spines, which revealed multilevel disk bulges and disk protrusions of uncertain clinical significance; and consultation with a neurosurgeon, who appears to be the claimant's primary treating provider. It is incidentally noted that several requests have been made for the claimant to obtain epidural steroid injections.

The most recent progress note provided dated April 23, 2012, is notable for comments that the claimant has had several denied epidural steroid injections, continues to have persistent complaints of neck and back pain, has persistent radicular symptoms about the arms and legs, remains on light duty at work, exhibits a wide-based gait, positive straight leg raise testing, has symmetric reflexes on exam, has no "major motor or sensory deficits," and is asked to obtain Ultram, Celebrex, and a lumbar epidural steroid injection.

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

Per ODG references, CT of the Lumbar and Cervical spines are not recommended. Magnetic resonance imaging has largely replaced computed tomography scanning in the noninvasive evaluation of patients with myelopathy. No compelling case has been made for the proposed CAT scans of the lumbar and cervical spines and/or CT myelography of the lumbar and cervical spines. These might be appropriate if the claimant was a candidate for spine surgery and if these procedures were being employed for the purposes of preoperative planning. In this case, the treating provider has suggested that the claimant is not presently a surgical candidate and should pursue epidural steroid injections prior to obtaining CT scanning and/or spine surgery.

Furthermore, the MRI of cervical and lumbar spines dated 1/19/2012 revealed small protrusion into the left neural forearm at C6-C7 which produces Foraminal encroachment. The treating neurosurgeon, however, interprets those findings as positive. If the findings are, indeed, positive as the neurosurgeon suggests, then obtaining further clarification of the anatomy via CT scanning and/or CT myelography is superfluous.

For all these reasons, the proposed CT scans of the lumbar and cervical spine are not medically necessary.



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**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR
OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN 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