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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/13/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CT Cervical Spine

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

M.D., Board Certified Orthopedic spine surgeon, practicing neurosurgeon

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

Official Disability Guidelines

Adverse determination notice 12/05/11

Adverse determination after reconsideration notice 01/12/12

Carrier response to request for IRO attorney 02/29/12

Initial exam and follow-up office visits MD 08/23/11-01/17/12

EMG/NCV 11/15/11

MRI lumbar spine 10/20/11

Appeal letters 12/26/11

Initial evaluation DC 07/29/11

Daily progress notes, DC 08/02/11-09/08/11

Adverse determination after reconsideration notice 10/03/11

Adverse determination notice 09/27/11

Authorization notice 08/11/11

Office note, DC 01/19/12

Functional capacity evaluation 09/15/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is male whose date of injury is xx/xx/xx. He was leaning against a table that collapsed and he fell to the ground. He was seen in an initial evaluation on 07/29/11 with the primary complaint of aching pain in the low back bilaterally, with pain radiating into both hips. The claimant's second complaint was aching pain in the mid back bilaterally. The claimant was treated conservatively with chiropractic/physical therapy. MRI of the lumbar spine dated 10/20/11 reported lumbar scoliosis is seen. No occult fracture or spondylolysis was noted. At L2-3 subluxation is seen with 4mm disc bulge flattening the thecal sac and mild canal stenosis. At L3-4 there is a 3mm subligamentous disc protrusion flattening the thecal sac. At L4-5 a 4mm annular disc bulge with bilateral facet joint arthrosis is seen, with mild bilateral foraminal encroachment. Electrodiagnostic testing performed 11/15/11 revealed evidence of acute L5 radiculopathy on the right and left. Physical examination on 10/11/11 reported no antalgic gait. The claimant can sit and rise without guarding in spine. Cervical spine alignment appears normal, but there is significant decrease in range of motion in all planes and neck movement is not smooth. There is increased rotation of right rather than left,

secondary to posterior cervical pain. Left upper trapezius still has mild myospasms present as compared to right. Lumbar spine has good alignment, normal pelvic tilt. He can flex lumbar spine until fingers are approximately 12 inches from ground. Extension is limited approximately 10-15%. Lateral bending left and right is approximately 10-15%. Palpation of lumbar spine revealed tenderness in midline at L4-5, L5-S1. He is okay on heels and toes.

An adverse determination was rendered on 12/05/11 regarding request for CT of cervical spine. It was noted plain films of cervical spine were ordered, but details of exam do not provide info that would suggest need for advanced imaging of cervical spine at this time.

An adverse determination after reconsideration was rendered on 01/12/12 in reference to request for CT of cervical spine. It was noted the claimant was leaning on stand, which collapsed injuring low back. He was treated with at least 12 therapy sessions to lumbar spine, unknown treatment to cervical spine. 10/11/11 MD report states the claimant is to continue physical therapy and x-rays of CT neck and lumbar; neck exam reflects decreased range of motion with no orthopedic tests or radiculopathy and normal heel/toe. 11/15/11 bilateral lower extremity EMG/NCV notes acute bilateral L5 radiculopathy. Cervical spine x-rays on 12/02/11 were approved with unknown findings. It was noted no supporting exam or other objective findings were submitted for neck CT. Reconsideration clinical submitted was 3 letters from the claimant to carrier dated 12/26/11 requesting various imaging studies to "determine if surgery is required."

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

This man sustained injuries secondary to fall when the table he was leaning on collapsed, causing him to fall to the ground. The patient primarily complained of low back pain. He was treated conservatively with chiropractic / physical therapy. There is no clear documentation of nature and extent of conservative treatment completed for cervical spine. It appears that plain radiographs of cervical spine were certified, but no radiology reports were submitted for review with objective findings on cervical x-rays. Per Official Disability Guidelines, CT scan of cervical spine is not generally recommended except for specific cases such as suspected cervical spine trauma with cervical tenderness--paresthesias in hand / feet, suspected cervical spine trauma--unconsciousness, or impaired sensorium. Other indications would include known cervical spine trauma with severe pain--normal plain films and no neurologic deficit, or equivocal or positive plain films with neurologic deficit. In this case there is no evidence of neurologic deficit and no plain films were submitted for review. The reviewer finds there is not a medical necessity at this time for CT Cervical Spine.

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)