Medwork Independent Review
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ACCREDITED INDEPENDENT REVIEW ORGANIZATION

NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION
Workers' Compensation Health Care Non-network (WC)

September 24, 2012

DATE OF REVIEW: 9/20/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Lumbar Spine CT Scan

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Texas State Licensed MD Board Certified Orthopedic Surgeon

REVIEW OUTCOME [PROVIDE FOR EACH HEALTH CARE SERVICE IN DISPUTE]
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)
Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
1. Texas Dept of Insurance Assignment to 9/6/2012,
2. Notice of assignment to URA 9/5/2012,
3. Confirmation of Receipt of a Request for a Review by an IRO 9/6/2012
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 9/6/2012
6. Letter from Insurance company 7/20/2012, 8/3/2012, pre-authorization intake form 7/17/2012, medical documents 7/11/2012, letter to insurance plan from physician 6/29/2012, preauthorization intake form 6/27/2012, medical documents 6/1/2012.

PATIENT CLINICAL HISTORY:
The female was injured in xx/xx/xx. Reportedly, she injured her low back. The attending physician's progress notes reveal ongoing back pain with left leg radicular pain that had somewhat improved as of mid July 2012. Exam findings had revealed decreased sensation along the left leg with a positive straight leg raise. X-rays had revealed a grade 1 spondylolisthesis with a pars defect at the L5-S1 level. There was a consideration for a CT scan of the lumbar

spine for additional evaluation. It was noted that in denial it was felt that there would be "no clinical understanding for clinical role of a computerized tomography in this case compared to an MRI scan." It was noted that there was no history of "significant trauma." It was also noted that there was evidence of the pars defect identified on the plain x-rays. The ODG guideline criteria reportedly was noted to be applicable to evaluate pars defects not identified on plain film x-ray; therefore, the CT scan was not felt to be reasonable or necessary in the denial letters.

Additional records reviewed, as noted, discussed the clinical records from the treating provider, who discusses that decreased disk height with grade 1 spondylolisthesis "the changes from 10 mm to 15 mm between flexion and extension" was noted on 07/11/2012 along with the pars defect at L5. The spondylolisthesis was felt to be "unstable." The CT scan was felt to be indicated "to evaluate the pars articularis fracture as well as the spondylolisthesis..." as per the treating provider. The additional denial letters were noted to reveal that "there are no documented neurologic deficits..." The ODG guideline indications for CT scan were noted to be in the cases of lumbar spine trauma with a neurologic deficit or a "seatbelt/chance fracture" along with myelopathy related to the spinal cord and to "evaluate pars defect not identified on plain x-rays..."

The prior attending physician's records from the summer of 2012 and the spring of 2012 were also reviewed, revealing a diagnosis of back pain and lumbar radiculopathy and spondylolisthesis.

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

Applicable ODG guidelines have not been met. Indeed, as noted in the denial letters, this patient has a well-documented pars defect in addition to documented spondylolisthesis. Without a history of a known direct traumatic injury to the spine and without neurologic deficit and with an already identified pars defect, at this time the guidelines for CT scan have not been met. The applicable ODG criteria have not been met and, therefore, the request for the CT scan of the lumbar spine does not appear medically reasonable and/or necessary based on those guidelines and the prior rationale documented within the denial letters is reasonable, appropriate, and denial opinions are, to be upheld.

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**

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- ☐ **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)**