

Core 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jan/16/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 1 CT scan of the lumbar spine with contrast

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D. Board Certified Internal Medicine

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that this request for 1 CT scan of the lumbar spine with contrast does not meet guideline recommendations and is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes dated 09/17/12, 10/01/12, 10/15/12, and 11/15/12
Previous utilization reviews dated 11/29/12 and 12/06/12

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury regarding his low back. The clinical note dated xx/xx/xx details the patient complaining of low back pain. Per the note, the patient has a history of low back surgery and 2 screws at the L4 and L5 levels. The patient was noted to have undergone back surgery in 1993. The note details the patient utilizing Neurontin and Naprosyn for ongoing pain relief. The clinical note dated 10/01/12 details the patient complaining of intermittent low back pain. The patient stated that the pain was more frequent. The patient was noted to be utilizing Lortab for pain relief. Per clinical note dated 10/15/12, the patient presented for a follow-up regarding his low back complaints. The patient was then referred to an orthopedic doctor. Per clinical note dated 11/15/12, the patient continued with low back pain. The patient stated that sex with his wife exacerbates his pain level.

Utilization review dated 11/29/12 resulted in a denial for a CT scan of the lumbar spine because the patient was still awaiting an evaluation by an orthopedic surgeon prior to the CT scan.

Utilization review dated 12/06/12 also resulted in a denial for a CT scan of the lumbar spine secondary to a lack of information regarding the rationale for the requested CT scan. Additionally, there was a lack of information regarding the patient's significant deficits

indicating the need for a CT scan.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation submitted for review elaborates the patient complaining of low back pain despite a previous surgical intervention. A CT scan of the lumbar spine would be indicated provided the patient meets specific criteria to include noted trauma with resulting neurologic deficits, infectious disease involving myelopathic findings, a pars defect not identified on plain x-rays, or failure of plain x-rays to confirm a fusion. There is a lack of information regarding the patient's significant clinical findings involving any neurologic deficits. Additionally, the x-rays did not reveal a fracture or pars defect. Further, there is a lack of information regarding any infectious diseases the patient may have. Given this lack of information, it is the opinion of the reviewer that this request for 1 CT scan of the lumbar spine with contrast does not meet guideline recommendations and is not medically necessary.

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)