

# P-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Sep/17/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Outpatient Lumbar CT

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

Board Certified 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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.**

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical note dated 01/10/05

Clinical note dated 01/27/05

Clinical note dated 02/07/05

Clinical note dated 02/16/05

Clinical note dated 03/11/05

Clinical note dated 05/19/05

Clinical note dated 07/05/05

Clinical note dated 08/22/05

Clinical note dated 10/20/05

Clinical note dated 01/19/06

Clinical note dated 03/16/06

Clinical note dated 05/18/06

Clinical note dated 08/03/06

Clinical note dated 09/21/06

Clinical note dated 01/12/07

Clinical note dated 01/29/07

Clinical note dated 04/30/07

Clinical note dated 05/15/07

Clinical note dated 06/07/07

Clinical note dated 08/03/07

Clinical note dated 11/15/07

Clinical note dated 02/14/08  
Clinical note dated 03/10/08  
Clinical note dated 05/19/08  
Clinical note dated 07/28/08  
Clinical note dated 08/11/08  
Clinical note dated 11/13/08  
Clinical note dated 01/08/09  
Clinical note dated 09/08/09  
Clinical note dated 03/19/09  
Clinical note dated 05/28/09  
Clinical note dated 08/03/09  
Clinical note dated 10/01/09  
Clinical note dated 12/17/09  
Clinical note dated 01/21/10  
Clinical note dated 03/03/10  
Clinical note dated 03/18/10  
Clinical note dated 10/14/10  
Clinical note dated 11/08/10  
Clinical note dated 01/17/11  
Clinical note dated 02/08/11  
Clinical note dated 02/17/11  
Clinical note dated 04/28/11  
Clinical note dated 06/30/11  
Clinical note dated 09/29/11  
Clinical note dated 12/29/11  
Clinical note dated 03/29/12  
Clinical note dated 06/18/12  
Clinical note dated 09/27/12  
Clinical note dated 11/26/12  
Clinical note dated 01/21/13  
Clinical note dated 04/18/13  
Clinical note dated 07/18/13  
Operative report dated 01/25/05  
Radiology report dated 01/25/05  
CT scan of the lumbar spine dated 01/25/05  
Operative report dated 02/01/05  
Radiology report dated 02/01/05  
CT scan of the cervical spine dated 02/01/05  
Operative report dated 02/16/05  
Radiology report dated 02/16/05  
Discharge summary dated 02/16/05  
Radiology report dated 03/11/05  
Operative report dated 05/15/07  
Discharge summary dated 05/15/07  
X-ray of the cervical spine dated 05/15/07  
X-ray of the cervical spine dated 08/23/07  
Radiology report dated 06/07/07  
X-ray of the cervical spine dated 02/14/08  
Operative report dated 03/07/08  
CT myelogram dated 03/07/08  
Operative report dated 03/25/08  
Procedural note dated 06/03/08  
Operative report dated 02/25/09  
Discharge summary dated 02/25/09  
Operative report dated 09/08/09  
Discharge summary dated 09/08/09  
Operative report dated 03/03/10  
MRI of the lumbar spine dated 02/08/11  
X-rays of the lumbar spine dated 02/08/11

Procedural note dated 02/18/11  
Procedural note dated 06/07/11  
Procedural note dated 10/17/12  
X-rays of the lumbar spine dated 02/13/13  
Procedural note dated 05/07/13  
Adverse determinations dated 07/31/13 & 08/09/13

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who is noted to have a long history of both cervical and lumbar region pain. The clinical note dated 02/08/11 details the patient complaining of neck pain with radiating pain into the left upper extremity. The MRI of the lumbar spine dated 02/08/11 revealed a disc bulge at L2-3, L3-4, and L5-S1. Previously implanted posterior rods and pedicle screws were noted at L4 and L5 along with a disc spacer type device at the L4-5 level. Decompression changes were noted at the L4-5 level. Minimal retrolisthesis of L3 was noted at L4. The x-rays of the lumbar spine dated 02/09/11 revealed no hardware complications. No abnormal translation on motion was identified with flexion or extension views at that time. The procedural note dated 03/18/11 details the patient undergoing an epidural steroid injection at L3-4. The procedural note dated 06/07/11 reported the patient undergoing an epidural injection in the lumbar region. The patient was noted to have radiating pain into the left lower extremity from the low back. The clinical note dated 06/18/12 revealed the patient complaining of increasingly severe mid lumbar pain with bilateral radicular hip and leg pain with numbness, dysesthesia, and weakness in the lower extremities. The clinical note dated 09/27/12 revealed the patient having undergone a coronary artery stent placement. The clinical note dated 11/26/12 mentions the patient having undergone an additional left sided L3-4 epidural injection in October of 2012. The clinical note dated 04/18/13 revealed the patient having undergone an epidural injection which did provide 2 months of benefit. The procedural note dated 05/07/13 revealed the patient having undergone an epidural injection at the left side at L4-5. On the clinical note dated 07/18/13, the patient is noted to have limited mobility in the low back. The patient was reporting severe levels of pain with increasing neurological deficits in the lower extremities.

The prior utilization review dated 07/31/13 resulted in a denial for a CT scan of the lumbar spine secondary to no sufficient documentation was submitted supporting the request.

The utilization review dated 08/09/13 regarding a CT scan of the lumbar spine resulted in a denial as no information was submitted regarding the patient's symptoms.

**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 having a long history of ongoing low back pain despite a number of injections and an operative procedure. The Official Disability Guidelines recommend a CT scan of the lumbar spine provided the patient meets specific criteria to include a previous spinal trauma resulting in neurological deficits or fracture; or myelopathy is noted in the appropriate distributions; or plain x-rays do not identify a PARS defect or a previous successful fusion. The patient is noted to have undergone several injections. However, no information was submitted regarding the patient's recent completion of any conservative therapies addressing the low back complaints. Additionally, no information was submitted regarding the patient's recent trauma leading to neurologic deficits or a fracture. No information was submitted regarding the patient's recent trauma leading to myelopathy. Given that no information was submitted regarding the patient's recent completion of any conservative therapies and taking into account that no information was submitted regarding the patient's recent trauma, this request is not indicated. As such, it is the opinion of this reviewer that the request for an outpatient CT scan of the lumbar spine is recommended as 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)