

# Independent Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Aug/19/2014

**IRO CASE #:**

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

CT of the lumbar spine

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

Board Certified Orthopedic Surgeon

**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)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who reported ongoing low back pain. A clinical note dated 07/01/14 indicated the patient previously undergoing decompression and laminectomy at L3-4 and L4-5 with a subsequent spinal cord stimulator placement. The patient was previously diagnosed with failed back surgery syndrome and post-laminectomy syndrome. The patient utilized MS Contin, oxycodone, Tizanidine, and Celebrex for pain relief.

The Utilization review dated 06/20/14 resulted in denial for CT scan of the lumbar spine as no progressive neurological deficits had been identified in the clinical documentation submitted for review.

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

The request strength at documentation indicated the patient complaining of ongoing low back pain despite previous surgical intervention. A CT scan of the lumbar spine is indicated for patients who have completed all conservative treatment and identified as having significant neurological deficits. The patient complained of low back pain. However no exam findings were indicative of neurological deficits in the lower extremities. It is unclear if the patient has completed of any recent conservative treatments addressing low back complaints. Given this, the request is not indicated as medically necessary. As such, it is the opinion of this reviewer that the request for CT scan of the lumbar spine is not recommended as 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)