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Notice of Independent Review Decision

DATE OF REVIEW: 9/29/2014

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CT Myelogram Scan of the Lumbar Spine.

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

M.D. Board Certified in Occupational 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)

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a male who has filed a claim for chronic low back pain reportedly associated with an industrial injury of xx/xx/xx. Patient has been treated with the following: analgesic medications; transfer of care to and from various providers in various specialties; earlier lumbar fusion surgeries; and unspecified amounts of physical therapy over the life of the claim. In a July 7, 2014 progress note, the applicant reported persistent complaints of low back pain, with numbness and tingling about the right foot and leg. The applicant did report some weakness from time to time. The attending provider stated that the applicant would need a repeat CT scan. The applicant was obese, with a BMI of 27. The applicant exhibited an antalgic gait with decreased sensorium and strength noted about the right lower extremity. In a July 29, 2014 Utilization Review Report, the claims administrator denied a request for CT scanning of the lumbar spine on the grounds that ODG reportedly did not support routine CT scanning outside of trauma or infection. It was acknowledged that the claimant had had multiple prior lumbar spine surgeries. In an August 1, 2014 Utilization Review appeal, the claims administrator again denied a CT myelogram of the lumbar spine, stating that the attending provider had not stated whether the applicant's symptoms worsened as compared to baseline. The patient subsequently appealed.

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

Per ODG references the requested "CT Myelogram Scan of the Lumbar Spine" Is medically necessary. As noted in ODG's Low Back Chapter, Computer Tomography topic, indications for CT imaging include "lumbar spine trauma: Trauma, neurologic deficit." While ODG's Low Back Chapter, CT topic does suggest that MRI imaging has largely replaced computer tomography, in this case, however, the applicant has had numerous prior spine surgeries and has indwelling spinal fusion hardware in place. Said spinal fusion hardware would likely obfuscate the value of lumbar MRI imaging, making CT imaging an



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appropriate test here. Contrary to what was suggested by the claims administrator, the applicant's axial low back pain complaints and radicular low back pain complaints do appear to be worsening over time. The applicant was described on July 7, 2014 as exhibiting diminished right lower extremity strength and sensorium. As there is a strong likelihood that the applicant would act on the results of the CT scan in question and pursue a surgical remedy were the CT in question sufficiently positive, CT imaging to evaluate the structural integrity of the lumbar spine and earlier fusion hardware as well as to evaluate the applicant's worsening radicular complaints and radicular signs is indicated. Therefore, the request is medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- 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