



14785 Preston Road, Suite 550 | Dallas, Texas 75254  
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### Notice of Independent Review Decision

**DATE OF REVIEW: 8/03/2015**

**IRO CASE #**

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

CT Scan without contrast, Thoracic.

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

M.D. Board Certified in Orthopedic Surgery and Sports 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 xx-year-old who was injured in a fall from a ladder xx/xx/xx with T11 and T12 burst fractures and paraplegia. He underwent posterior spinal fusion from T10-L1 that day. In the two follow up notes available, the patient has continued to be paraplegic without change in neurologic exam. Plain x-ray interpreted at visit on 11/19/2014 showed alignment of implants to be good without evidence of fusion at that point. MRI of the lumbar spine done 12/11/2014 due to low back pain showed partial visualization of T9-L2 posterior fusion with T11 compression deformity sub-optimally visualized, L4-5 disc dehydration, and no spinal cord abnormalities. Per the last clinic note from 1/12/2015, the patient remains paraplegic and is going to PT twice a week. He has no sensation other than a burning pain in the legs and no volitional motor function. Plan is for follow up in 6 months with a CT scan of the thoracic spine at that time.

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

Per ODG references, the requested "CT Scan without contrast, Thoracic" is not medically necessary. There is no indication for a CT scan for routine follow up of a spinal fusion. There is no recent plain X-ray documented that suggests the fusion is not healing. There is also no change in the status of the patient clinically to warrant a CT scan. Therefore, the request of a CT of the thoracic spine is not certified.

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

- AHCP- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN



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- 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