



TEXAS DEPARTMENT OF INSURANCE

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DATE OF REVIEW: May 20, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CT scan, Cervical Spine

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

The TMF physician reviewer is a licensed Spinal Orthopedic Surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the proposed treatment.

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 or not medical necessity exists for each of the health care services in dispute.

It is determined that the CT scan, Cervical Spine is not medically necessary in the treatment of this patient’s medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a back injury on xx/xx/xx while lifting boxes. Prior treatment includes spinal cord stimulator placement/replacement, epidural steroid injection to the lumbar spine, Cervical Fusions, and lumbar spine surgeries. The provider's current request for a CT scan of the cervical spine without contrast has been denied by the payer in appeal.

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

A CT scan of the cervical spine is not indicated for this care plan based on review of the records. The patient does not meet the need for the CT. No acute trauma is documented and no severe pain. Plain x-rays to look at dynamic instability can be considered. A CT/Myelogram would definitely be a study to consider in the future if neurologic signs develop; however, the patient has no neurologic signs at this time. Indications for a CT (known recent trauma, infection or tumor) are not present in this review.

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

- ACOEM- AMERICAN 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)

Disclaimer language:

NOTICE ABOUT CERTAIN INFORMATION LAWS AND PRACTICES

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