

Independent Resolutions Inc.

An Independent Review Organization

Phone Number:
(682) 238-4977

835 E Lamar Blvd. 394

Arlington, TX 76011

Fax Number:
(817) 385-9610

Email:independentresolutions@irosolutions.com

Notice of Independent Review Decision

Case Number

Date of Notice: 10/12/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Physical Medicine and Rehabilitation

Description of the service or services in dispute:

CT scan of the lumbar spine without contrast

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 an injury to his low back. The CT scan of lumbar spine dated xxxx revealed pedicle screw instrumentation from L4 to S1. Moderate bilateral neural foraminal stenosis was identified on the right at L4-5 and L5-S1. The x-rays of the lumbar spine dated 06/10/15 revealed an L4 to S1 laminectomy and fusion without acute abnormalities. Mild multilevel degenerative changes were identified. The clinical note dated 06/19/15 indicates the patient having complaints of low back pain with rating pain to the right lower extremity. The patient rated the pain as 7/10. There is indication the patient had undergone physical therapy which provided minimal pain relief. The note indicates the patient was a current everyday smoker at that time. Tenderness was also identified in the lumbar musculature. The clinical note dated 07/15/15 indicates the patient continuing with low back complaints. Upon exam tenderness continued in the gluteal region. The patient was able to demonstrate 50 degrees of lumbar flexion with 20 degree 10 degrees of extension and 20 degrees of bilateral lateral rotation. The clinical note dated 08/12/15 indicates the patient continuing with lumbar region pain. The patient had been recommended for a CT scan the lumbar spine. The utilization reviews dated 08/05/15 and 07/27/15 resulted in denials for the CT scan the lumbar spine as insufficient information had been submitted regarding the patient's neurological changes.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The documentation indicates the patient of a long history of ongoing low back pain. A CT scan is indicated for patients with findings consistent with neurological deficits. No information was submitted regarding patient's ongoing neurological deficits or strength, sensation, or reflex changes in the lower extremities. Given the lack of information regarding the patient's neurological involvement, this request is not indicated as medically necessary. As such is opinion this reviewer that the request for a CT scan the lumbar spine without contrast is not indicated 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 and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical Literature (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)