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An Independent Review Organization

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DATE NOTICE SENT TO ALL PARTIES: Apr/19/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: CT Lumbar

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD - Board Certified 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of this reviewer that the request for CT Lumbar is medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male with back pain. On XX/XX/XX, an MRI of the lumbar spine found the patient to be status post posterior lumbar fusion at L3-S1, with expected postsurgical changes. There was a disc bulge at L2-3, with bilateral neural foraminal narrowing and mild spinal stenosis. There was a disc bulge at L1-2, with mild right neural foraminal narrowing. The screws were present at L3-4 and at L4-5 and L5-S1. On XX/XX/XX, the patient returned to clinic. He reported his pain had severely increased with pain at 9/10. On exam, he had 5/5 strength and x-rays were obtained showing hardware in the canal that appeared to be fractured hardware. The CT scan was recommended to evaluate that hardware.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On XX/XX/XX, a utilization review report noted the request for a CT of lumbar spine was non-certified and used Official Disability Guidelines Low Back Chapter as the referenced source. It was noted the results for prior imaging were not submitted for review and there was no documentation of how the CT results would affect future medical care in a 23+ year old claim.

The guidelines indicate that indications for imaging such as this would include to evaluate a successful fusion if plain x-rays do not confirm fusion. The records indicate the provider has obtained plain x-rays, which apparently show hardware in the canal. Thus, this would be indication for which further imaging would be supported to evaluate not only the possibility of fractured hardware, but to further assess the integrity of the fusion as the patient has reported increasing pain.

It is the opinion of this reviewer the request for CT Lumbar is medically necessary and the prior denial is overturned.

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)