INFORMATION PROVIDED TO THE IRO FOR REVIEW:
Records were received and reviewed from the following parties: XX XX XX

These records consist of the following (duplicate records are only listed from one source): Records reviewed from XX XX XX:
XX XX XX:
Denial Letters-X
X, MD/The Hospitals of X:
Encounters and Procedures-X
Imaging Order-X
Office Visit Notes-X
XX Order-X
PT Referral-X
X:
XX Report-X
X Therapy Centers:
Preauthorization Requests-X

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:
This patient is a X who sustained an industrial injury on X. Injury occurred when X was S. Past surgical history was positive for S. A review of records documented conservative treatment to include X. The X orthopedic report indicated

that X had good and bad days with X depending on X work activities. X was reporting current pain in the outer part of X. X was taking X. X exam documented X of the greater X, normal X with pain, X test. X exam documented X. The diagnosis included X. The treatment plan recommended x-rays of the X CT scan without contrast. X-rays of the X on X were reported with findings of X, well-preserved X, normal X, and normal X. Work status was documented as light duty. The X utilization review report indicated that the request for CT scan of the X was non-certified. The rationale stated guidelines preferred x-rays status post X for suspected there was no documentation of contraindication to MRI, and there was no specific indication for the CT scan of the X. The X utilization review report indicated that the denial of the request for CT scan of the X. The rationale stated that the patient did not meet Official Disability Guidelines criteria. X had plain films that were within normal limits, and a X MRI with X. It was noted that the X could be better determined by bone scan, and CT scan may be medically necessary based on the result of the XX scan. It was noted that on peer-to-peer discussion, the orthopedic surgeon reported the patient had persistent X, normal serial plain films, and had an MRI of the X with prominent XX due to previous X surgery.

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

The Official Disability Guidelines state that CT scan of the X is recommended only for specific indications. Compared with plain radiography and MRI, computed tomography (CT) is a second-line imaging tool for X conditions and should only be used if preferred modalities are specifically contraindicated. Indications for imaging include :X, X [X-ray preferred]; X, evaluate X [X-ray preferred]; and, X, suspect X [X-ray

preferred]. Guidelines recommend XX scan for specific indications, but only following other clinical testing and imaging. Indications include X complications.

This patient presents with persistent X pain and X following a X injury. X is status post prior X. Clinical exam findings have documented tenderness of the XX greater X with pain. Serial x-rays of the X have been reported within normal limits. MRI of the X had X. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment X has been submitted. Under consideration is a request for X CT scan without contrast for a diagnosis of X. The Official Disability Guidelines recommend x-rays for evaluation of X complications. There is no specific indication provided to support the medical necessity of a CT scan of the X at this time. There is no compelling rationale presented or extenuating circumstances noted to support the medical necessity of this request as an exception to guidelines. Therefore, this request is not medically necessary.

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**

☐ **AHRQ- 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**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**