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Notice of Independent Review Decision

SENT TO: Texas Department of Insurance
Managed Care Quality Assurance Office
(MCQA) MC 103-5A Via E-mail
IRODecisions@tdi.texas.gov

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: X and Dr. X.

X: X denial letter, peer review by X, MD X denial letter, peer review by X, MD X, X appeal letter from X and X (X), X and X notes and intake, and X operative report.

Dr. X : X handwritten clinical note from X, X X x-ray report, X typewritten clinical notes X, X records (date illegible), X X report, X notes X, X reports from X Rehab Hospital (X), X X Plans of Care, X X US report, X X x-ray report, X admission report for X, X notes by X, MD, X laboratory reports, and X pathology report.

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-year-old X who sustained an X injury on X relative to a X. X was diagnosed with X including X, X, and X. X underwent open treatment and reduction of a X and correction of X. The X neurosurgical report indicated that the

patient presented with complaints of grade X pain, most severe on the X, with X and X pain. The patient reported increased X pain above and below the surgical site. Pain was worse with certain X or after staying in X periods of time. X denied any X. X was taking X on an as needed basis. X was last seen in X. X exam documented functional X X neurologic exam documented normal sensation, X. The diagnosis included X pain. A discussion of symptoms, past radiological studies, current exam findings, and treatment options was documented. The treatment plan recommended MRI and CT scan of the X for further evaluation of X symptoms prior to making any final decisions about X treatment plan. If negative, a X would be ordered. The X utilization review determination letter indicated that the request for CT scan of the X without contrast was non-certified as not medically necessary. The rationale stated that there was no justification provided why a CT scan of the X was being requested at the same time as an MRI, or that radiographs were performed prior to considering a CT scan. Additionally, there was no mention of recently increasing pain or symptoms and there was a normal X neurological examination. The X provider appeal letter indicated that the patient was injured in a X and required a X. X currently had pain. The neurosurgeon needed a CT scan of the X to inspect for failure of X MRI to look at the X. X met other criteria listed in the denial letter relative to X pain, new or progressive symptoms or clinical findings with history of X to evaluate X. Reconsideration was requested to allow coverage for the requested X. The X utilization review determination letter indicated that the denial of the request for CT scan of the X without contrast was upheld as not medically necessary. The rationale stated the records did not establish that the patient’s current pain symptoms had not responded to an appropriate course of conservative care, and there was no evidence that current plain film

radiographs did not confirm X. It appeared the patient had not had any treatment since at least X. The X neurosurgical addendum to the 5X appeal letter stated that once any mechanical failure in X construct had been ruled-out with imaging, the plan was to treat X conservatively.

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

The Official Disability Guidelines recommend CT for the X for limited indications. Guidelines state that CT is the preferred first test for X, especially when meeting high-risk criteria for X injury. CT scan is recommended for X pain or X, uncomplicated, including X, X. Guidelines state that MRI is recommended over CT (unless an MRI could not be performed), for post-surgery for evaluation of X status when radiographs are inconclusive, and for X pain or X new or progressive symptoms or clinical findings with history of X surgery.

This patient presents status post X for treatment of multiple X. X reports increased X pain above and X the surgical site, with X pain. Clinical exam findings did not evidence a focal neurologic deficit. X MRI and CT have been recommended for treatment planning. There is no documentation of recent X x-rays. It was noted that CT scan was indicated to rule-out failure of X. The Official Disability Guidelines criteria for CT scan have not been met at this time. Guidelines recommend initial radiographs for evaluation of fusion status. MRI is recommended as the next step to evaluate X status, or for new or progression X pain in patients with history of X surgery. Therefore, the prospective request for CT scan of the X without contrast 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**

☐ **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)**