

# IRO America Inc.

An Independent Review Organization

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Notice of Independent Review Decision

**DATE OF REVIEW:** AUGUST 20, 2007

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Lumbar myelogram post CT scan

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

Board Certified Orthopedic Surgeon

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Cervical x-ray, 03/07/07 and 04/30/07

Note, 03/07/07, 03/19/07

NCS, 03/14/07

Work note, 03/16/07

Office notes, Dr., 04/09/07, 05/03/07, 05/15/07, 06/15/07 and 07/19/07

Cervical MRI without contrast, 04/27/07

Lumbar MRI without contrast, 05/24/07

Lumbar and thoracic x-ray, 05/25/07

CT/Myelogram, 07/05/07

Laboratory report, 07/05/07

Hospital records for CT/myelogram, 07/05/07

Review, Dr. 07/12/07

Review, Dr. 07/20/07

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a xx year-old male who was unloading a box spring off a truck on xx/xx/xx when the wind caught it and he twisted his back. The claimant is a smoker and weighs 328 pounds. He was evaluated on 03/07/07 for complaints of back pain, finger tingling and arm numbness since. He reported undergoing chiropractic treatment with a diagnosis of thoracic outlet syndrome. Physical examination demonstrated positive Adson's and Roo's with good pulses; as well as full cervical and lumbar motion with minimal lumbar tenderness and negative straight leg raises. Cervical spine radiographs from 03/07/07 were within normal limits; however, they did not include the C7-T1 level. Electrodiagnostic studies completed on 03/14/07 were consistent with severe bilateral median neuropathy at the wrist. The claimant treated with Celebrex and Flexeril. He had ongoing complaints of insomnia and mood changes related to his pain complaints and treated with Amitriptyline. He was noted to be taking Tylenol for headaches. The claimant underwent neurosurgical evaluation on 04/09/07 with findings of obesity, intact lower extremity reflexes and good strength. MRI evaluation of the cervical spine from 04/27/07 noted C6-7 extrusion without further details provided. Lumbar MRI evaluation conducted on 05/24/07 indicated L4-5 and L5-S1 broad based bulges without significant stenosis or foraminal narrowing and mild bilateral degenerative facet disease. Lumbar radiographs from 05/25/07 noted L4-5 disc space narrowing. Thoracic radiographs from the same day demonstrated a dextro convex curvature of the lower lumbar spine. A cervical CT/ myelogram completed on 07/05/07 were positive for minimal disc bulging with minimum impression at C4-5 and C5-6. A lumbar CT/myelogram has been requested.

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

After a careful review of all medical records, the Reviewer's medical assessment is that the lumbar CT/ myelogram would not be recommended as medically necessary. The claimant has reported primarily subjective complaints of low back pain. Physical examination has demonstrated intact lower extremity strength, reflexes and sensation. Radiographs and MRI evaluation fail to demonstrate any compressive pathology or significant degeneration. His conservative regimen has not included physical therapy for the lumbar spine as an attempt to address his musculoskeletal complaints. In the absence of radicular pathology, myelopathic findings, compressive lesion or surgical intervention, the benefit of CT/ myelogram is unclear.

Official Disability Guideline: Low Back- Myelography  
Recommended as an option. Myelography OK if MRI unavailable

Rothman-Simeone, The Spine, Fifth Edition; Chapter 12, page 1

**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
  - Rothman-Simeone, The Spine, Fifth Edition; Chapter 12, page 187
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)