

C-IRO, Inc.

An Independent Review Organization
7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726

Notice of Independent Review Decision

IRO REVIEWER REPORT TEMPLATE -WC

DATE OF REVIEW:

JULY 18, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Weight bearing/standing lumbar myelogram and post CT scan lumbar spine

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

M.D. 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Office note of Dr. 11/13/06, 03/21/07, 05/23/07, 06/19/07

EMG/NCV 12/27/06

X-rays orbits 03/07/07

MRI lumbar spine 03/07/07

Authorization request 04/18/07

Authorization request 05/30/07

notification of Determination 06/04/07

HEALTH AND WC NETWORK CERTIFICATION & QA 9/27/2007
IRO Decision/Report Template- WC

Dr. fax to Dr. 06/19/07
reconsideration 06/25/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female pipe fitter who suffered a lumbar injury while lifting pipe that was in the ground. She was diagnosed with lumbar stenosis and bilateral lower extremity radiculopathy right greater than left. An EMG/NCV study on 12/27/06 confirmed a right S1 radiculopathy and an MRI on 03/07/07 showed severe central canal and subarticular recess stenosis at L4-5 in addition to a Grade I spondylolisthesis at that level. The claimant reported aggravation of pain with any activity and inability to function due to severe pain. Examination by Dr. on 05/23/07 noted worsening of symptoms, with right leg spasms, inability to straighten the right leg and hyperextension of the toe especially on the right. The claimant walked with a limp on the right, was not able to hop on the right, and reflexes were hypoactive and equal. Straight leg raise testing was positive on the right at 75 degrees and negative on the left, and sensation was decreased along the L5 dermatome. Dr. requested authorization of a weightbearing standing lumbar myelogram and post myelogram CT scan to further evaluate the spondylolisthesis in lieu of flexion/extension X-rays.

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

Weight bearing, standing, lumbar myelogram, and post CT lumbar does not appear to be medically reasonable and necessary in this female who has had conservative measures. An MRI which demonstrates severe central canal and sub-articular recess stenosis at L4-5 and grade I spondylolisthesis. There has been no flexion/extension radiographs and the Reviewer does not think there is any clear cut reasoning within the documentation provided of what benefit further imaging would provide as the imaging to date is consistent with the clinical examination and clinical picture. Therefore, the Reviewer agrees with the previous denial for weight bearing/standing lumbar myelogram and post CT scan lumbar spine.

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
Official Disability Guidelines Treatment in Worker's Comp 2007 Updates: Low Back – CT myelography
- 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)