SIRO

Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 5/8/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of a lumbar myelogram w/ post CT scan.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is an Osteopathic Physician who is board certified in Orthopedics and has greater than 15 years of experience.

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)

The reviewer agrees with the previous adverse determination regarding the medical necessity of a lumbar myelogram w/ post CT scan.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Letters: 3/14 and 4/03/2007.
Records Doctor/Facility:
    Letters: 3/16 and 4/11/2007.
    Myelogram/CT: 2/15/1994.
Records from Carrier:
    Report: 4/11/2007.

Reports: 3/19 to 3/30/2007.
Exam: 2/14 and 3/26/2007.
MD, Report: 2/14/2007.
Reports: 12/6/1994 and 3/6/2007.
MD, Reports: 6/29/1994 to 2/16/1995.
MD, Reports: 3/9/1993 to 1/25/1994.
MD, Reports: 3/29/1994 through 7/18/1994.
Op Note: 8/16/1993.
Report: 2/26/1994.

PATIENT CLINICAL HISTORY [SUMMARY]:

This female injured her low back. This injury resulted in a lumbar fusion. The patient returned to work in 1995 and worked until she had an injury to her right shoulder. At that time patient retired.

The patient has sporadic episodes of severe pain in the low back, but denies any numbness or tingling to her lower extremities.

Physical examination reveals that the lumbar spine, sciatic notch, and SI joints are not tender. Lumbar range of motion is restricted in extension. Straight leg raise is unremarkable and strength and sensation are 5/5.

The only test result supplied for this review was a Myelogram/CT Scan on 02/15/1994. Treatment has been with limited activity, multiple medications, and group psychotherapy.

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

The reviewer states that the ODG indications for CT/Myelogram include lumbar spine trauma with a neurologic deficit or myelopathy which is a result of the trauma or if an MRI is unavailable.

The patient's injury was years ago and there is no documentation to support the request for a myelogram/CT Scan. There is no evidence of spinal trauma or neurological deficits.

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)**
  Helms: Fundamentals of Skeletal Radiology, 3rd Edition