# IRO Express Inc.

**An Independent Review Organization**
**835 E. Lamar Blvd. #394**
**Arlington, TX 76011**
Phone: 817-274-0868
Fax: 817-549-0310

**DATE OF REVIEW:** OCTOBER 8, 2007

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**
Lumbar myelogram with 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**
Office notes 03/28/2000, 04/22/04, 06/10/04, 04/06/2006, 06/05/07
Operative report, 04/19/2000
Lumbar myelogram and CT, 04/08/2004, 04/28/06
Office note 05/10/07
EMG/NCS, 05/17/07
Lumbar ESI L3-4, 05/18/07
Pre-Authorization requests Lumbar myelogram, 08/02/07, 09/05/07
No ODG Guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**
This xxyear old female claimant reportedly had a long history of chronic low back pain and lower extremity pain since a work related injury in 1991 and had undergone previous low back surgeries. On a 05/10/07 physician visit, increased back and bilateral leg pain was reported. On examination, the claimant was neurologically intact with diffuse tenderness over the lower back and weakness in the quadriceps and calf muscles. The

claimant was diagnosed with bilateral lower extremity radiculopathy post multiple lumbar surgical procedures.

An EMG / NCS followed on 05/17/07 which revealed findings consistent with lumbar radiculopathy from L2 to S1 of mild to moderate severity. The claimant then underwent a lumbar steroid injection on 05/18/07 with some transient benefit. A follow up physician visit dated 06/05/07 noted the claimant seen in an emergency department for a complaint of paralysis. The claimant was diagnosed with lumbar radiculopathy along with a solid fusion L4 to S1 and a cervical herniated nucleus pulpous. According to the records, the treating physician recommended a CT myelogram and then would consider treatment based on the results. A previous lumbar CT myelogram done on 04/28/06 showed L4-L5- S1 fusions , annular bulging at L2-3 and L3-4 without stenosis and right facet joint arthrosis present at L2-3 . Compared to a previous study, there was no evidence of any interval change.

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

The claimant has a history of chronic lower back pain and lower extremity pain. She has undergone five prior lumbar surgeries. She had a CT myelogram in April of 2004 and another CT myelogram in April of 2006. She does not appear to have an interval injury since her most recent CT myelogram. There is no recent physical examination data of the lumbar spine. The claimant's subjective complaints do not appear to be different than they were at the time of the most recent CT myelogram performed in April of 2006. It does not appear that further information would be gleaned from a repeat CT myelogram study. Therefore, after a careful review of all medical records, the Reviewer's medical assessment is that the lumbar CT myelogram is not considered medically necessary.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Low Back: Myelograph

## 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)**