

Independent Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: 04/20/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Computed Tomography, Lumbar Spine, with contrast material

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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

OD Guidelines

Adverse Determination Letters 03/05/2008, 04/02/2008

Clinic note Dr. 02/13/2008

Prior reviews 03/05/2008, 04/02/2008

MRI of the lumbar spine report 11/12/2007

Dr. clinic note 01/07/2008

Dr. clinic notes 01/18/2008, 02/29/2008

Clinic note Dr. 02/12/2008

IME Dr. 01/07/2008

PATIENT CLINICAL HISTORY [SUMMARY]:

This xxyear-old female has a date of injury xx/xx/xx while transferring a patient from the wheelchair to her bed. She has low back pain and pain shooting down her legs, primarily the right leg. She has had therapy and numerous injections. Neurological examination reveals right knee flexor/extensor and right dorsiflexor/plantar flexors at 4+/5. EMG 01/08/2008 was unremarkable. A recent MRI (11/12/2007) showed minimal bilateral neuroforaminal narrowing at L4-L5 and mild foraminal stenosis bilaterally at L5-S1. The provider is recommending a CT myelogram of the lumbar spine, as well as a functional anesthetic discogram at L5-S1.

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

The CT myelogram is not medically necessary. The MRI adequately shows the pathology present in the lumbar spine. According to the ODG, “Myelography OK if MRI unavailable, contraindicated (e.g. metallic foreign body), or inconclusive. ([Slebus, 1988](#)) ([Bigos, 1999](#)) ([ACR, 2000](#)) ([Airaksinen, 2006](#)) ([Chou, 2007](#)) Magnetic resonance imaging has largely replaced computed tomography scanning in the noninvasive evaluation of patients with painful myelopathy because of superior soft tissue resolution and multiplanar capability. Invasive evaluation by means of myelography and computed tomography myelography may be supplemental when visualization of neural structures is required for surgical planning or other specific problem solving. ([Seidenwurm, 2000](#)).”

After a careful review of all medical records, there is no evidence that the MRI is inconclusive nor is there evidence that the provider needs an MRI for surgical planning. Therefore, the CT myelogram is not medically necessary

References/Guidelines

ODG “Low Back” chapter
CT & CT Myelography

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)