



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 8/20/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The service under dispute is a CT myelogram (dynamic weight bearing) of the lumbar spine from L4 to S1.

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

The reviewer is a board certified Orthopedic Surgeon who has been practicing for greater than 10 years.

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
and Dr.

These records consist of the following (duplicate records are only listed from one source): : 8/6/08 letter , PLN-11 form 2/5/08, 9/10/07 peer review by , MD, 6/24/08 adverse determination letter and 7/1/08 adverse determination letter.

Dr. : 1/14/08 to 6/16/08 chart notes by Dr. , caudal ESI reports 7/23/07 to 5/19/08, 6/21/07 lumbar MRI report and explanation of internal fixation report of 7/21/05.

We did not receive the ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured on the job inxx/xx. He underwent an L4/5, L5/S1 discectomy, and 360 degree fusion in 2003 followed by the hardware removal procedure. During the course of treatment the patient has had chronic pain and has been on narcotic analgesic medications on a chronic basis.

Recently, he has undergone ESI's and as of 6/16/08, Dr. has proposed a CT myelogram. The exam revealed limited lumbar ROM in flexion, negative dural tension signs and a normal myotomal examination.

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

The ODG indicates "Not recommended except for indications below for CT. CT Myelography OK if MRI unavailable, contraindicated (e.g. metallic foreign body), or inconclusive. 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. The new ACP/APS guideline as compared to the old AHCPR guideline is more forceful about the need to avoid specialized diagnostic imaging such as computed tomography (CT) without a clear rationale for doing so.

Indications for imaging -- Computed tomography:

- Thoracic spine trauma: equivocal or positive plain films, no neurological deficit (this criterion does not apply in this case)
- Thoracic spine trauma: with neurological deficit (does not apply in this case)
- Lumbar spine trauma: trauma, neurological deficit (does not apply in this case as no neurological deficit is noted in the examination provided)
- Lumbar spine trauma: seat belt (chance) fracture (does not apply)
- Myelopathy (neurological deficit related to the spinal cord), traumatic (does not apply)
- Myelopathy, infectious disease patient (does not apply)
- Evaluate pars defect not identified on plain x-rays (no documentation of this in radiographs)
- Evaluate successful fusion if plain x-rays do not confirm fusion (documentation of 4/18/08 indicates that the fusion is solid)

Based upon the lack of documentable evidence that this procedure is necessary, this procedure is found to be not medically necessary at this time. Furthermore, the reviewer indicates that there is nothing in the ODG to support dynamic weight bearing testing.

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)