



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 08/19/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar myelogram with post myelogram CT scan

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

Board Certified in Orthopedic Surgery

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.

Lumbar myelogram with post myelogram CT scan - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with , M.D. dated 01/04/07, 03/22/07, 05/03/07, 07/09/07, 09/10/07, 11/12/07, 01/14/08, 02/26/08, 05/29/08, and 06/24/08

An operative report from Dr. dated 03/07/07

A physical therapy evaluation with , P.T. dated 04/05/07

Evaluations with M.D. dated 04/20/07, 08/17/07, 09/14/07, 11/09/07, 12/07/07, 12/28/07, and 06/23/08

Physical therapy progress notes from , P.T. dated 04/30/07 and 05/24/07

A physical therapy evaluation with , P.T. dated 06/11/07

Physical therapy progress notes from Mr. dated 07/09/07 and 09/07/07

Functional Capacity Evaluations (FCEs) with an unknown provider (signature was illegible) dated 08/21/07 and 08/23/07, 11/27/07 and 11/28/07, 02/19/08 and 02/20/08

A work hardening progress note from , M.A., L.P.C. dated 02/25/08

Request notes from Dr. dated 06/03/08 and 06/25/08

A peer review report from , M.D. dated 06/05/08

A letter of non-authorization, according to the ODG, from Dr. dated 06/06/08

An EMG/NCV study interpreted by an unknown provider dated 06/23/08

Patient identification information dated 06/24/08

A letter of non-authorization, according to the ODG, from , M.D. dated 07/03/08

A position statement from CMS dated 07/31/08

The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On 01/04/07, Dr. recommended lumbar spine surgery. On 03/07/07, Dr. performed unknown lumbar spine surgery. On 04/20/07, Dr. recommended increased Vicodin ES, discontinuation of Soma, continued Ambien, and starting Ibuprofen. On 07/09/07, Dr. I prescribed physical therapy three times a week for six weeks. An FCE on 08/21/07 and 08/23/07 indicated the patient functioned at the light physical demand level. On 09/07/07, Mr. recommended continued physical therapy. On 11/12/07, Dr. recommended a work hardening and conditioning program. On 12/07/07, Dr. recommended Daypro, Ambien, Vicodin ES, and Valium. An FCE on 02/19/08 and 02/20/08 indicated the patient functioned at the medium physical demand level. Work hardening was performed with Ms. on 02/25/08. On 02/26/08, the patient was released to full work duty and was placed at Maximum Medical Improvement (MMI) as of 02/27/08 by Dr. . On 05/29/08, Dr. I recommended a myelogram CT scan. On 06/06/08, Dr. wrote a letter of non-authorization for the CT myelogram. On 06/23/08, Dr. prescribed Cymbalta. On 07/03/08, Dr. wrote a letter of non-authorization for the CT myelogram.

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

The patient had a postoperative MRI that Dr. said was benign. The patient has good evidence of fusion on his plain films. His electrodiagnostic studies are normal. His physical examination is normal. There is no evidence that a CT myelogram would demonstrate any pathology that has not already been evaluated. The patient has pain complaints that do not appear to have a physiologic origin. It has been thoroughly evaluated with the electrodiagnostic studies and the MRI. Repeating the evaluation with a CT myelogram would not add useful information and is not supported by the ODG or current professional references such as *The Spine*, Simeone and Rothman, Edited by Herkowitz et. al. Therefore, the requested lumbar myelogram with post myelogram CT scan is neither reasonable nor necessary.

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 AND KNOWLEDGE BASE
- 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)