

Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 07/18/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Myelography, lumbosacral, radiological supervision and interpretation on 04/08/08

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., F.A.C.S., board certified Orthopedic Surgeon experience in the evaluation and treatment of the spine injured patient

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
724.2	72265	NA	Prosp		04/08/2008				Upheld

INFORMATION PROVIDED FOR REVIEW:

- TDI IRO assignment
- Letters of denial 04/11/08 & 05/14/08, including criteria used in denial (ODG)
- Previous review dated 04/10/08 (denial)
- Appeal response dated 05/13/08 (denial)
- Clinic notes from 04/07/05 through 05/05/08 (17 entries)
- Operative reports dated 07/20/07, 06/27/06, and 08/09/05
- X-ray reports dated 10/02/06, 04/14/06, and 08/09/05
- Discharge summaries from hospitalizations 07/11/06 through 07/14/06, 06/27/06 through 06/29/06, 09/23/05 through 09/24/05

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This xx-year-old Hispanic male suffered a lifting injury to the lumbar spine region on xx/xx/xx. He had persistent symptomatology in spite of appropriate treatment. A lumbar myelogram with MRI scan was performed revealing compressive neuropathy. Laminectomy/discectomy was performed on 09/25/05 at the level of L5/S1. He has persistent symptoms, and a repeat study was performed on 04/14/06, revealing recurrent compressive neuropathy. A repeat laminectomy/discectomy with fusion at the level of L5/S1 was performed on 06/27/06. He has had persistent bilateral leg pain subsequently. A request for repeat lumbar myelogram with CT follow through has been submitted and denied with appeal and denial.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

This patient has persistent pain without evolving neurologic findings. Criteria as stated in the ODG Guidelines, Spine Chapter, are not met for repeat lumbar myelogram with CT follow through.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, clinical experience and expertise in accordance with accepted medical standards.
- Mercy Center Consensus Conference Guidelines.
- Milliman Care Guidelines.
- ODG-Official Disability Guidelines & Treatment Guidelines, 2008, Spine Chapter
- Pressley Reed, The Medical Disability Advisor.
- Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
- Texas TACADA Guidelines.
- TMF Screening Criteria Manual.
- Peer reviewed national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)