

US Resolutions Inc.

An Independent Review Organization

71 Court Street

Belfast, Maine 04915

Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 31, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar myelogram with post CT scan

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

MD, 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)

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.

The reviewer finds that medical necessity does not exist for lumbar myelogram with post CT scan.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

First report, Dr. , 07/12/08

Office notes, Dr. , 07/16/08, 07/28/08, 08/25/08, 09/22/08

Rehab note, 07/30/08

OP report, 08/05/08

Bone scan, 09/08/08

Patient profile, 09/22/08

Fax authorization request, 09/25/08

Fax appeal sheet, 09/30/08

Peer review, Dr. , 09/30/08

Peer review, Dr. , 10/06/08

Case notes, , RN, 10/08/08
Two pages of a possible diagnostic study, illegible
ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year old male with a date of injury xx/xx/xx to his back. The claimant has a history of a 2008 left shoulder surgery. Dr. reported on a 07/12/08 exam that back pain had failed conservative management. He reviewed an MRI and stated it showed a small disc at left lateral L4-5 with some facet changes. Dr. , the treating physician, stated on a 07/12/08 exam that the claimant had twelve therapy visits and continued with back pain. The x-ray that day showed mild lumbar spondylosis. An MRI reportedly revealed an L4-5 herniated nucleus pulposus, a small bulge. On a 09/22/08 exam, Dr. noted that the low back pain was unimproved. The claimant had marked decrease in lumbar range of motion in flexion and extension with pain. A 08/25/08 x-ray revealed no instability but there was spondylosis with disc space narrowing. The diagnosis was sciatica, low back pain, mild lumbar radiculopathy, and displacement of intervertebral disc.

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

The reviewer finds there is no medical necessity for the requested CT myelogram lumbar spine with post CT scan. There appears to be a recent lumbar MRI documenting L4-L5 disc changes as well as the fact that there is no documentation in the medical record of a neurologic deficit or progressive loss of function following this MRI. There is a normal bone scan which would rule out any type of lumbar fracture and it is unclear from the medical records reviewed why a CT myelogram lumbar spine has been requested.

While ODG supports the use of CT myelogram in patients with trauma, progressive neurologic deficit, or pars defect, that does not appear to be the case in this patient, plus there has been an MRI which gives essentially the same type of information that can be seen on a CT myelogram.

Therefore, since this claimant has already had an MRI and there is no documentation of a clinical change in condition following the MRI and there is no discussion by the patient's treating practitioner exactly why he has requested a CT myelogram, the reviewer finds that medical necessity does not exist for lumbar myelogram with post CT scan.

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)