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Notice of Independent Review Decision

DATE OF REVIEW: 10/17/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

C-spine myelogram and C-spine CT post-myelogram, both done on **5/6/2008**

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

Certified by the American Board of Orthopaedic Surgery, and fellow-ship trained in surgery of the spine.

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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Retrospective	850.9	72126	Overturned
		Retrospective	850.9	A4215	Overturned
		Retrospective	850.9	76376	Overturned
		Retrospective	850.9	A4550	Overturned
		Retrospective	850.9	72240	Overturned
		Retrospective	850.9	77002	Overturned
		Retrospective	850.9	62284	Overturned

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		Retrospective	850.9	Q9967	Overtured
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INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization

Claim forms

Employer's First Report of Injury dated xx/xx/xx

Work status reports

Medical notes dated 9/12/07, 9/14/07, 9/25/07, 9/26/07, 9/27/07, 9/28/07, 10/8/07, 10/16/07, 10/23/07, 11/5/07, 11/20/07, 11/26/07, 12/3/07, 12/26/07, 1/15/08, 1/16/08, 2/13/08, 3/3/08, 3/19/08, 4/24/08, 5/15/08, 6/26/08

Impairment rating letter

CT C-spine post myelogram dated 5/6/08

Myelogram C-spine dated 5/6/08

Official Disability Guidelines cited but not provided

PATIENT CLINICAL HISTORY:

According to the information provided, this patient suffered a work-related injury on xx/xx/xx, when she fell off of a chair, hitting her chin and jarring her back. The patient, who has a history of prior cervical fusion C5-6 and C6-7, has had persistent cervical pain with radicular pain since the fall on 9/2/07. . She has had physical therapy and epidural steroid injections for the pain. On **5/6/08** she had a cervical spine myelogram and a CT scan of the cervical spine post-myelogram, which showed a 2 mm disc protrusion at C3-4 and right neural foraminal stenosis at C3-4 and at C4-5.

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

In the Reviewer's opinion, both the C-spine myelogram and the C-spine CT scan post-myelogram that were done on **5/6/08** were indicated and medically necessary for this patient, and all ODG criteria for myelogram and CT have been met in this case.

The Reviewer noted that this patient has a severe injury to her cervical spine, and she is also at increased cervical spine injury risk due to her prior cervical surgery and instrumentation. The Reviewer further noted that this patient has

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well-documented cervical instability and facet arthrosis syndrome, with severe cervical radiculopathy.

The Reviewer explained that myelogram and CT scan post-myelogram are both still the gold standard worldwide for cervical spine evaluation. In this case, the tests were indicated to assist with identifying treatment options, including the possibility of surgery for this patient who still has severe symptoms despite appropriate conservative therapy.

The Reviewer added there were no other imaging alternatives available for the patient, as an MRI with a prior instrumentation patient would miss too much detail, given all of the scatter that would be evident. Also it would not be appropriate to obtain a myelogram without also obtaining a post-myelogram CT scan.

In the Reviewer's opinion, both the C-spine myelogram and the C-spine CT scan should be authorized with complete payment for each.

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**

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- 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)**