



Notice of Independent Review Decision

**IRO REVIEWER REPORT**

**DATE OF REVIEW:** 4/6/09

**Date Amended:** 4/23/09

**IRO CASE #:**

**NAME:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Determine the appropriateness of the previously denied request for:

1. Myelography, lumbosacral RS & I (72265).
2. CT lumbar spine C+ MATRL (72132).
3. Injection procedure Myelography/CT (62284).

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

Texas licensed Neurosurgeon.

**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 previously denied request for:

1. Myelography, lumbosacral RS & I (72265).
2. CT lumbar spine C+ MATRL (72132).
3. Injection procedure Myelography/CT (62284).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- Texas Department of Insurance Independent Review Organization Sheet dated 4/1/09.
- Texas Department of Insurance Fax Cover Sheet dated 4/1/09.
- Notice to of Case Assignment Sheet dated 4/1/09
- Notice to Utilization Review Agent of Assignment of Independent Review Organization sheet dated 4/1/09.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 4/1/09.
- Activity Note dated 3/31/09 through 2/1/09.
- Request for a Review by and Independent Review Organization Form dated 3/30/09.
- Follow-Up Note dated 2/23/09, 1/15/09, 11/3/08, 11/6/07, 8/30/07.
- Non-Authorization: State Clinical Review Criteria Not Met Report dated 2/16/09.
- Texas Outpatient Reconsideration Decision: Non-Authorization Report dated 2/16/09.
- Texas Outpatient Non-Authorization Recommendation Report dated 2/6/09, 7/16/07.
- Report of X-Ray Examination dated 12/5/08.
- Lumbar Spine MRI with and Without Contrast Report dated 12/5/08.
- History and Physical Examination Report dated 11/3/08.
- Medical History Questionnaire Form dated 11/3/08.
- Treatment Following Test Sheet dated 11/3/08.
- Pain Drawing Sheet dated 11/3/08.
- Follow-Up Consultation and Examination Report dated 1/21/08, 12/7/07, 11/9/07, 2/13/08.
- Pre-Authorization Request Sheet dated 12/7/07, 2/14/08.--
- Pain Management Program Description sheet dated 12/5/07, 1/22/08.
- Treatment Memo dated 12/3/07, 3/6/07, 8/15/06, 7/31/06, 7/9/06, 6/16/06, 5/20/06, 3/11/08, 6/3/08, 6/11/08, 6/27/08, 7/30/08, 12/12/08.
- Evaluation/Medical History Summary Report dated 11/28/07.
- Drug Reduction Schedule Sheet dated 11/28/07.
- Initial Functional Capacity Evaluation Report dated 11/28/07.
- Interdisciplinary Pain management Treatment Plan Summary dated 11/28/07.
- Physical Medicine and Rehabilitation Consultation Report dated 10/19/07.
- Fax Cover Sheet/Pre-Authorization Request dated 8/23/07, 7/11/07, 5/7/07, 3/7/07, 10/16/06, 6/23/08, 11/17/08, 11/24/08.
- Daily Note dated 8/22/07, 8/20/07, 8/17/07, 8/15/07, 8/13/07, 8/10/07, 8/8/07, 8/3/07, 8/1/07, 7/30/07, 7/25/07.
- Progress Note dated 8/20/07, 8/10/07, 5/3/07, 3/1/07, 2/5/07, 1/4/07.

- Plan of Care Sheet dated 7/10/07, 12/8/08
- Brief Discharge Summary dated 6/22/07, 1/26/07, 12/15/06.
- Denial Reconsideration Summary dated 7/18/07.
- Initial Evaluation Report dated 7/10/07.
- Prescription dated 8/23/07, 7/2/07, 3/1/07, (unspecified date).
- Medical Imaging Report dated 4/19/07, 8/3/06, 6/10/08.
- Request for authorization Sheet dated 2/15/07, 2/6/07, (2)(unspecified date).
- Statement of Medical Necessity Sheet dated 1/24/07.
- Letter of Medical Necessity dated 1/31/07.
- Operative Report dated 6/15/07, 12/6/06, 7/2/08.
- Initial Neurosurgical Consult Report/Letter dated 11/20/06, 10/10/06.
- Texas Workers Compensation Work Status Report dated 9/8/06, 3/28/08, 7/25/08, (3)(unspecified date).
- Authorization Request/Letter dated 6/23/06.
- Physical /Functional Progress Report dated 1/21/08 through 1/8/08.
- Team Staffing Note (unspecified date).
- Request for Medical Records Note dated 3/31/08.
- Initial Examination Report dated 3/28/08.
- Lumbar Myelogram with Contrast Medical Imaging Report (2)dated 6/10/08.
- Lumbar Spine Medical Imaging Report dated 6/10/08.
- E-Mail/Procedure Request note dated 6/23/08, 7/31/08.
- Workmans Comp Preauthorization Request Sheet (unspecified date), 12/17/08.
- Follow-up Examination Report dated 6/20/08, 7/25/08.
- Functional Capacity Evaluation Report dated 2/29/08.
- Electromyography/Nerve Conduction Study Report dated 10/17/07.
- Pre-Authorization Intake Form (unspecified date).
- Electromyography/Nerve Conduction Study Request Sheet dated 11/14/08.
- Patient Referral Form dated 11/14/08.
- Patient Information Sheet (unspecified date).
- MRI of Lumbar Spine without Contrast Report dated 4/20/07.
- Request for Aquatic Exercise Prescription dated 11/24/08.
- Initial Evaluation/Examination Sheet dated 12/8/08.
- Report of X-Ray Examination dated 12/5/08.
- Notification of Workers' compensation Referral sheet dated 12/12/08.
- Fax cover Sheet/Authorization request Approval note dated 2/3/09.
- Myelogram Exam Requisition Form (unspecified date).
- MRI of Lumbar Spine with and without Contrast Report dated 12/5/08.
- Fax cover Sheet/Reconsideration Note dated 2/9/09.
- Texas Utilization Review Reconsideration and Appeals Procedure Workers' Compensation Summary (unspecified date).
- Telephone Note dated 11/21/08.
- Relieve pain and restore muscle function article (unspecified date).
- Pre-Authorization Intake Form (3)(unspecified date).

- **Diagnosis Note/Authorization Request Note (unspecified date).**

No guidelines were provided by the URA for this referral.

**PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:** xx  
**Gender:** Male  
**Date of Injury:** xx/xx/xx  
**Mechanism of Injury:** Not provided

**Diagnosis:** Status post L2-L3, L4-L5 and L5-S1 laminectomy, kyphoplasty, decompressive laminectomy at L2-L3.

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

This is a xx year-old male with a date of injury xx/xx/xx, when he slipped and fell on some oil grease. He is status post L4-L5 and L5-S1 discectomy 12/2006. In 01/2007, he fell at home and sustained an L1 compression fracture. He underwent an L1 kyphoplasty for a compression fracture on 06/15/2007. He had also been diagnosed with a right trochanteric bursitis, as well as a right gluteus medius tendinitis. He complained of continued back pain and proximal right leg pain. He had physical therapy and injections. He smoked one pack of cigarettes per day. He underwent a psychological evaluation on 11/28/2007. A myelogram/CT on 06/10/2008, revealed a high grade stenosis at L2-L3. There was disc desiccation and bulging at L4-L5 with bilateral neuroforaminal narrowing. At L5-S1 there was severe disc desiccation with significant bilateral neuroforaminal narrowing. An electromyogram/nerve conduction velocity (EMG/NCV) study on 10/17/2007 of the right lower extremity was normal. In June 2008, he underwent an L2-L3 decompressive laminectomy. An MRI of the lumbar spine with and without contrast report 12/05/2008, revealed moderate stenosis at L2-L3 due to a bulging disc. There was severe bilateral neuroforaminal narrowing at L5-S1. There was moderate bilateral neuroforaminal narrowing at L4-L5. The provider had ordered a repeat EMG/NCV and had ordered a myelogram/CT. The myelogram/CT is not medically necessary based on the submitted documentation. The claimant underwent a recent MRI of the lumbar spine (December 2008) which showed several levels of pathology. It was unclear what, if any, further information a CT myelogram will add to or affect his treatment. According to the ODG, "Low Back" chapter, CT myelogram is necessary if the MRI is contraindicated, unavailable, or inconclusive. Also, it can be used as pre-surgical planning. In this case, there was not a sufficient explanation or insight as to why the myelogram/CT is being ordered. Therefore, based on the available documentation, the CT myelogram is not medically necessary. (If the myelogram is not necessary, then obviously, the injection would not be necessary.)

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
- X** ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.  
Official Disability Guidelines (ODG), Treatment Index, 6<sup>th</sup> Edition (web), 2008, Low back—CT/CT myelogram.
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).