

Parker Healthcare Management Organization, Inc.

4030 N. Beltline Rd Irving, TX 75038

972.906.0603 972.255.9712 (fax)

Notice of Independent Review Decision

**DATE OF REVIEW: NOVEMBER 30, 2009 AMENDED DECEMBER 3, 2009
DECEMBER 10, 2009**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Cervical spine CT myelogram

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical medicine and Rehabilitation, and is engaged in the full time practice of medicine

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

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

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
722.4	72240		Prosp	1					Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-17 PAGES

Respondent records- a total of 28 pages of records received to include but not limited to:
TDI letter 11.9.09; letter 9.25.09, 10.21.09; notes from Dr 6.22.09-9.10.09

Requestor records- a total of 0 pages of records received to include but not limited to:
11.9.09-faxed first request for records; 11.16.09-faxed 2nd request for records; 11.20.09-left voicemail regarding records. No response

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient sustained an on the job injury on xx/xx/xx.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

The ODG guidelines specifically state that a myelogram CT can be used when a specific problem is trying to be addressed, even though typically an MRI is considered superior. In this particular case an MRI has already been performed. Subsequent to the MRI, a trial spinal cord stimulator was performed and the patient is now having worse radicular symptoms. A CT spine post myelography could help determine if there is any retained material from the lead and if there is any evidence of cord swelling or any particular area of narrowing causing compression of the fecal sack.

Therefore, I believe that as an alternate to an MRI which as already been performed, a CT scan of the cervical spine with myelography is a reasonable and appropriate treatment and does meet the criteria of the ODG guidelines in this particular instance as outlined above.

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

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

XX 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)