

Notice of Independent Review Decision

**IRO REVIEWER REPORT**

DATE OF REVIEW: 11/05/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

CT myelogram of the cervical and lumbar spine to include flexion and extension views

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

The TMF physician reviewer is board certified in pain management with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the CT myelogram of the cervical and lumbar spine to include flexion and extension views are not medically necessary to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Information for requesting a review by an IRO – 10/15/09
- Letter of utilization review determination by. – 08/11/09, 08/25/09
- Notice of Assignment of Independent Review Organization – 10/15/09
- Office visit notes by Dr. – 07/27/09
- Benefit Dispute Agreement – 06/03/09
- Authorization to Release Information and Assignment of Benefits – 07/27/09
- History and Physical exam by Dr. – 07/27/09
- Report of MRI of the lumbar spine – 05/18/09
- Office Follow Up notes by Dr.– 07/02/09

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/xx resulting in pain to the neck, shoulder and low back. He has been diagnosed with cervical and lumbar spine disc disease with cervical and lumbar radiculopathy as well as right shoulder tendonitis and right shoulder impingement syndrome. The notes state that the patient has been treated with physical therapy and medications without relief. The treating physician is recommending CT myelogram of the cervical and lumbar spine to include flexion and extension views.

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

ADG criteria states that CT/myelogram may be helpful in surgical planning. The provider states that the etiology of the cervical/arm pain has been determined, i.e., the 2 level disc protrusions. So a CT/myelogram is excessive and not indicated.

**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)