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Notice of Independent Review Decision

DATE OF REVIEW: 11/19/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical myelograpy with radiological supervision and interpretation

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

Board Certified in Orthopedic Surgery

REVIEW OUTCOME

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

X 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.

Cervical myelograpy with radiological supervision and interpretation - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An evaluation with M.D. dated 08/10/09
Preauthorization requests from Neuro Imaging dated 09/08/09 and 09/29/09

Letters of non-certification, according to the Official Disability Guidelines (ODG), from Group dated 09/10/09 and 10/01/09
Letters of request from Dr. (no credentials were listed) dated 09/25/09 and 10/28/09
A peer review report from M.D. dated 09/08/09
A peer review report from D.C. dated 09/29/09
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On 08/10/09, Dr. recommended a cervical CT myelogram. On 09/10/09 and 10/01/09, wrote letters of non-certification for a cervical myelogram. On 09/25/09 and 10/28/09, Dr. requested a cervical myelogram CT scan. On 10/28/09, Dr. provided a Medical Dispute Resolution request.

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

There is insufficient clinical information presented as to the patient's past treatment. At this time, surgery is not the primary consideration as there is no indication as to the patient's presurgical treatment. Further, the patient has been evaluated in the past with an MRI and electrodiagnostic studies. The location of the patient's pain is not documented. Based on the ODG criteria, an MRI is preferable to a CT myelogram. The MRI has already been obtained and therefore, the requested cervical myelography with radiological supervision and interpretation is neither reasonable nor necessary and the previous adverse determinations should be upheld.

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 AND KNOWLEDGE BASE**
- ☐ **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**

X **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**

☐ **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)**