



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 9/30/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a CT myelogram lumbar.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. This reviewer has been practicing for greater than 10 years in this specialty and performs this type of procedure in his office.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a CT myelogram lumbar.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

MD

These records consist of the following (duplicate records are only listed from one source): Records reviewed from MD: notes – 8/17/09, Operative Report – 5/5/04; DO Follow-up notes – 3/10/08-3/24/09; MD Lumbar Myelogram report – 6/6/02, Lumbar Spine CT Post Myelogram report – 6/6/02; FCE report – 12/29/08.

Records reviewed from: Denial letter – 8/26/09 & 9/3/09; Physician Advisor Report – 8/25/09 & 9/3/09; Myelogram Script – 8/17/09 and Patient Information Sheet.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who was injured xx/xx/xx at work and has undergone 3 lumbar surgeries and spinal cord stimulator implant. She complains of chronic pain, has a history of stroke since her surgery, and her stimulator was removed for stroke evaluation. Recent trauma is denied, but she complains of worsening left leg pain. Multiple comorbidities exist and her narcotic usage appears to have increased. Neurologically she has normal gait, 5/5 motor normal sensation to light touch, negative seated SLR, possible slight left EHL weakness. CT/myelogram is requested for evaluation.

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

According to the ODG: Trials find no benefit to routine lumbar imaging (radiography, MRI, or CT) for low back pain without indications of serious underlying conditions, and recommend that clinicians should refrain from routine, immediate lumbar imaging in these patients.

Indications for imaging -- Computed tomography:

- Thoracic spine trauma: equivocal or positive plain films, no neurological deficit
- Thoracic spine trauma: with neurological deficit
- Lumbar spine trauma: trauma, neurological deficit
- Lumbar spine trauma: seat belt (chance) fracture
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, infectious disease patient
- Evaluate pars defect not identified on plain x-rays
- Evaluate successful fusion if plain x-rays do not confirm fusion

The patient does not meet the ODG criterion for this procedure; therefore, a CT myelogram lumbar is not medically necessary.

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)**