

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 08/11/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar myelogram post CT scan 62287, 72132

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

The TMF physician reviewer is a board certified neurosurgeon 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 lumbar myelogram and post CT scan 62287, 72132 are medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 07/29/10
- Notification of Determination from – 12/03/08,12/22/08, 04/15/09, 06/28/09, 07/15/09, 06/08/10, 07/01/10
- Letters from Dr. to Dr.– 05/09/05 to 05/27/10
- Report of myelogram – 10/05/01, 12/16/03
- Report of post myelogram CT scan – 10/05/01, 12/16/03
- Specific and Subsequent Medical Report by Dr.– 02/20/97
- Report of post-operative back x-rays – 02/01/00
- Portion of a medical record from Medical Center –02/10/99, 02/01/00, 02/24/00, 05/04/00

- Recommendation for Spinal Surgery by Dr.
- Preauthorization for lumbar discogram with post CT scan from – 06/15/99
- Preauthorization for lumbar myelogram with post CT scan from – 11/15/99
- Specific and subsequent medical report by Dr.– 05/20/97 to 08/10/00
- Operative report for discogram by Dr.– 06/18/99
- History and Physical by Dr.– 06/18/99
- Report of lumbar CT after discogram – 06/18/99
- Result of Spinal Surgery Second Opinion Process – 07/23/99
- Office visit notes by Dr.– 03/30/98 to 07/01/99
- Report of myelogram by Dr.– 01/22/99
- Report of cervical myelogram – 12/12/97
- Preauthorization from for cervical myelogram with Post CT scan – 12/03/97, 09/27/01
- Operative report for discectomy – 02/01/00
- Letter from Dr. to Dr.– 11/09/00 to 11/07/05
- Report of x-rays of the lumbar spine – 05/04/00, 11/09/00, 10/11/02
- Notice of Independent Review Assignment – 10/07/03, 10/28/03
- Clinic record from Pain Clinic – 10/11/02 to 12/06/05
- Preauthorization from for paravertebral nerve block – 09/24/02
- Operative report for steroid injection – 12/06/05, 02/13/08, 08/04/09
- Notice of IRO decision – 02/10/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he was doing some lifting work. This resulted in pain to the cervical spine as well as to the lumbar spine. He has been treated with myelograms, epidural steroid injections and spinal surgery. The patient is having increasingly severe lumbar pain and bilateral hip and leg pain, mainly on the left. He has also developed some weakness in his left foot and the treating physician is recommending a lumbar myelogram with CT scan.

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

Lumbar myelography is clearly appropriate and indicated in the clinical setting of recurrent lumbar radiculopathy in a previously operated fusion patient who has failed conservative care. The prior surgery can distort anatomy enough such that it renders MRI difficult to interpret and making myelo/CT often times the only useful diagnostic test.

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)