

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 01/29/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

72265 Myelography Lumbosacral – Rad S
72132 CAT Scan, lumbar spine; with contrast

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

The TMF physician reviewer is a licensed chiropractor 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 72265 myelography lumbosacral – Rad S, 72132 CAT Scan, lumbar spine; with contrast 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 – 01/19/10
- Adverse Determination Letter – 12/16/09, 12/29/09
- Rx to Imaging for CT/Myelogram spine – 12/10/09
- Preauthorization letter from Dr. – 12/01/09
- Therapy notes – 12-02-09 to 12/07/09
- Initial consultation and healthcare palpatory exam – 12/01/09
- Report of MRI of the lumbar spine – 09/10/09
- Report of functional capacity examination – 11/04/09
- Request for preauthorization of myelogram and post CT – 12/10/09
- Notes – 05/14/09 to 12/10/09
- History and Physical examination by Dr. – 10/08/09
- Notice of Disputed Issue and Refusal to Pay Benefits – 11/11/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx while at work. This resulted in pain and injury to his lower back. An MRI of the lower spine revealed mild disk narrowing and disk dehydration at L4-L5. The patient has been under chiropractic care and the treating doctor is recommending that the patient undergo a lumbar myelogram with post myelogram CT scan.

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

The treating doctor states that the lumbar spine MRI performed on this patient is inconclusive. However, the MRI clearly demonstrates the condition of the patient's lumbar spine as of 09/10/09. The MRI dated 09/10/09 revealed L4-5 mild disk narrowing and disk dehydration. There is no evidence of lumbar disk herniation or nerve root compression. There is no central canal or foraminal stenosis at any level. In addition the designated doctor examination on 10/08/09 states "it is possible that the claimant sustained a muscular strain as a result of the activities required of him at work on xx/xx/xx. It is unlikely that he sustained any displacement of the disk or any neurological injury as a result of this episode". A FCE was performed on 11/04.09 and the patient was released to return to restricted duty on 12/07/09. Therefore, based on the medical record documentation, the ODG guidelines criteria for the requested services have not been met.

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)