



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 12/29/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under review include a lumbar CT myelogram.

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 Physical Medicine and Rehabilitation. The reviewer has been actively practicing for greater than 15 years and requests this type of procedure on a case by case basis in daily practice.

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 medical necessity of a lumbar CT myelogram.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Dr. .

These records consist of the following (duplicate records are only listed from one source): Dr.: handwritten notes by unknown physician 7/9/09 through 11/10/09, exam report of 7/9/09, 10/21/09 CPT check off sheet from, 9/17/09 denial letter, 9/15/09 screening and admission authorization sheets, CIWA-ARF report undated and 9/15/09 release of records.

: 11/12/09 denial letter, 11/19/09 denial letter, 11/20/09 report by Dr., 12/8/09 denial letter and 11/13/09 denial letter.

We did not receive a copy of the ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a woman who was injured in xx/xx while lifting and moving file cabinets at work yielding lower back pain. She has had a broad range of treatments which has failed to significantly relieve her disability. Treatment has included, medication, therapy, injections and a total of eight thoracic and lumbar surgeries. There has been an implantation of a spinal cord stimulator. Her medical records of 10/7/09 notes that she has detoxed from all medications. Her past history includes alcohol abuse, smoking and suicide attempts.

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

The ODG indicates that CT myelography is not recommended except for indications below for CT. CT Myelography OK if MRI unavailable, contraindicated (e.g. metallic foreign body), or inconclusive. Magnetic resonance imaging has largely replaced computed tomography scanning in the noninvasive evaluation of patients with painful myelopathy because of superior soft tissue resolution and multiplanar capability. Invasive evaluation by means of myelography and computed tomography myelography may be supplemental when visualization of neural structures is required for surgical planning or other specific problem solving. The new ACP/APS guideline as compared to the old AHCPR guideline is more forceful about the need to avoid specialized diagnostic imaging such as computed tomography (CT) without a clear rationale for doing so. A new meta-analysis of randomized trials finds no benefit to routine lumbar imaging (radiography, MRI, or CT) for low back pain without indications of serious underlying conditions, and recommends 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 reviewer notes that the medical information provided fails to establish the presence of necessary medical conditions or findings that meet the ODG criteria for the requested diagnostic procedure. Therefore, the procedure is found to be not medically necessary at this time.

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)