



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 12/30/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Myelogram W/CT Scan
Right Lower Extremity EMG/NCV

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

Board Certified in Psychiatry and Neurology

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.

Lumbar Myelogram W/CT Scan – UPHELD
Right Lower Extremity EMG/NCV – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Lumbar Spine MRI, M.D., 08/03/05, 10/13/05
- Evaluation, M.D., 08/11/05
- EMG/Nerve Conduction Study, Dr., 08/25/08
- Lumbar Epidural Steroid Injection (ESI), Dr., 09/02/05
- Lumbar Myelogram, Dr., 11/16/05

- Lumbar Spine CT, Dr. 11/16/05
- Follow up, Dr., 09/28/05, 10/20/05, 11/14/05, 12/07/05, 01/04/06, 01/18/06, 02/01/06, 03/03/06, 04/05/06, 05/04/06, 07/06/06, 07/25/06, 08/18/06, 09/05/06, 10/03/06, 11/03/06, 12/05/06, 03/06/07, 05/03/07, 05/22/07, 06/05/07, 08/09/07, 08/16/07, 08/14/07, 09/25/07, 10/25/07, 12/21/07, 12/27/07, 02/22/08, 04/25/08, 11/21/08, 12/18/08, 03/24/09, 08/25/09
- Bilateral Lumbar Medial Branch Blocks, Dr., 03/22/06
- U/S Lower Extremity Venous Left Leg, Dr., 04/14/06
- Bilateral Lumbar Medial Branch Rhizotomies, Dr., 04/19/06
- Skelaxin Refill, Dr., 04/27/06
- Evaluation, Wayne Paullus, M.D., 06/06/06, 04/09/07
- Chest X-Ray, , M.D., 04/05/07
- Operative Report, Dr., 04/09/07
- Lumbar Spine X-Rays, , M.D., 04/09/07
- Discharge Summary, Dr., 04/14/07
- Lumbar Spine X-Rays, Dr., 06/12/07, 09/11/07, 12/21/07, 03/11/08
- Follow up, Dr., 04/05/07, 04/24/07, 06/12/07, 09/11/07, 09/25/07, 03/11/08, 07/22/08, 11/06/09
- Lumbar Spine CT, , M.D., 03/19/08
- Lumbar Hardware Injection, Dr., 04/18/08
- Correspondence, Dr., 06/18/08
- Designated Doctor Evaluation (DDE), M.D., 11/26/08
- MRI of the Lumbar Spine, M.D., 09/17/09
- Denial Letter, Mutual, 11/17/09, 12/02/09
- The ODG Guidelines were provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient was injured while lifting a heavy object. He had undergone x-rays, MRI's, CT scans, an EMG/NCV and finally surgery. He was reported to be treating with Skelaxin and Tramadol.

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

The study of choice for imaging of the lumbar spine is a lumbar MRI scan, not a CT-myelogram. CT-myelograms are indicated only if the lumbar MRI scan is not available, or is contraindicated, or is inconclusive. The patient had a recent lumbar MRI scan on 09/17/09 showing no surgical lesion for disc pathology. Concerning the EMG, the EMG would not be medically necessary as the patient does not have clinical signs objectively on his latest physical examination by the treating physician, Dr. Eiss, or the Designated Doctor, nor any objective motor deficits, reflex asymmetries, or positive straight leg raising maneuvers. Hence, there is no objective evidence of a radiculopathy; therefore, an EMG nerve study of the right leg would not change the management of the patient, and is therefore not indicated. At this time, neither requested study is medically reasonable or 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)**