

SENT VIA EMAIL OR FAX ON
Jul/05/2010

True Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/05/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar CT Myelogram

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Denial Letters 4/22/10 and 5/5/10

OP Report 7/30/08

Dr. 1/28/09 thru 4/1/10

Rehab Centre 2/4/09

MRI 2/9/09

Dr. DC 7/22/09 thru 6/10/10

L-Spine Series 9/16/09

Dr. 10/8/09

Neuro 12/29/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with a date of injury xx/xx/xx, when he slipped and fell on some gravel. In 07/30/2008 he underwent a left L5-S1 discectomy. His neurological examination on 04/01/2010 revealed 3+/5 muscle strength of the gastrocnemius decreased left ankle jerk,

and hypesthesia over the S1 dermatome. Only hypesthesia in the S1 distribution was present on an examination of 01/28/2009. An MRI of the lumbar spine 02/09/2009 reveals postoperative changes at L5-S1 as well as moderate central disc herniation. There is asymmetric disc bulging to the left at L3-L4. At L4-L5 there is broad-based bulging of the disc. The provider believes there is a recurrent disc at L5-S1. Reportedly, the claimant has undergone a psychological assessment, indicating a favorable surgical intervention. He was seen by Dr., orthopaedist, on 12/29/2009, who also felt that there was a recurrent disc at L5-S1 and felt that operative intervention was warranted. The provider states that plain films of the lumbar spine 01/15/2010 shows a retrolisthesis of L5 on S1, although there is not a report submitted for review. The provider believes that the claimant is a surgical candidate and is requesting a CT myelogram for operative planning.

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

The lumbar myelogram with CT is medically necessary. According to the ODG, "Low Back" chapter, a myelogram is indicated if the MRI is inconclusive. The provider believes that there is contact of the nerve root seen on MRI, and on examination, the claimant has evidence of an S1 radiculopathy. Therefore, a CT myelogram would be appropriate to better analyze the lower lumbar spine and to ascertain if there is, indeed, compromise of the S1 nerve root.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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)