

SENT VIA EMAIL OR FAX ON  
May/19/2010

## IRO Express Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: (817) 349-6420

Fax: (817) 549-0310

Email: resolutions.manager@iroexpress.com

### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

May/18/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Lumbar Myelogram with Post CT Scan

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

Board Certified Neurologist with 30 years experience in clinical 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

Denial Letters 4/7/10 and 2/25/10

Radiology Reports 9/23/09

Dr. 1/13/10 thru 3/31/10

Dr. 2/1/10 thru 4/19/10

Rehab Notes 11/2/09 thru 1/8/10

**PATIENT CLINICAL HISTORY SUMMARY**

On x/xx/xxxx, Mr. injured his low back and left ankle when he slipped and his left foot went under an electric pallet jack causing a fall. Physical therapy notes suggest good improvement after each session. Examination on 2/1/10 documents positive left SLR at 45 degrees and weakness of tibialis anterior, gastrocnemius and EHL on the left as well as decreased sensation in L5 and S1 distribution on the left. An MRI lumbar spine shows a 2mm disk protrusion toward the right at L4-5 and a 3-4mm broad protrusion with mild bilateral foraminal narrowing and moderate canal stenosis at L5-S1. Examination on 3/31/10 shows

improvement in back pain following epidural steroid injection but his ankle remains painful. In addition a diagnosis of sacro-iliitis is raised.

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

This patient has improving low back pain. He has a continuing ankle injury. Continued conservative treatment of the back should continue as recommend by the ODG. A myelogram would not address the pertinent issue at this time and is not indicated per the ODG.

**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)