

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/13/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical and lumbar myelogram and CT

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

M.D., board certified in Orthopedic Surgery
Board Certified in Spine Surgery

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

ODG Guidelines, Neck and Upper Back Chapter
Adverse Determination Letters, 4/15/10, 3/25/10
M.D. 4/5/10, 3/15/10
Medical Center 3/3/10
M.D. 3/9/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is and has neck and back pain. He is reported to have bilateral lower extremity pain. Records indicate he was a carpet installer. An MRI scan has shown left-sided C5/C6 foraminal stenosis, and lumbar MRI scan showed canal stenosis, 5.5 mm, with a spondylolisthesis, pars defect, and hypertrophic facet. There is a note in the medical records of L5/S1 sensory deficit. There is no clinical or neurological note that this reviewer saw that indicated there are any myelopathic changes.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

Based upon the Official Disability Guidelines and Treatment Guidelines, which are statutorily mandated in the State of Texas, a myelogram with post myelogram CT scan would be of value for surgical planning in a case where there was specific criteria including fracture, infection, myelopathy due to spinal cord injury, or the necessity to evaluate pars defect that were not seen on plain films, and to evaluate fusion. In this case, the MRI scan findings are unequivocal and clear. Records indicate the claimant has significant stenosis secondary to his spondylolisthesis and has documented neurological deficit. The medical provider has not explained how further information could be obtained from the CT scan or CT myelogram that would change the clinical treatment. It is for this reason that the ODG Guidelines cannot be set aside, and the previous adverse determination could not be overturned. The reviewer finds that medical necessity does not exist for Cervical and lumbar myelogram and CT.

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)