

C-IRO Inc.

An Independent Review Organization
7301 RANCH RD 620 N, STE 155-199A
Austin, TX 78726
Phone: (512) 772-4390
Fax: (512) 519-7098
Email: resolutions.manager@ciro-site.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/04/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
LESI with Fluoroscopy @ L3-4 and Lumbar Myelogram w/CT

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

M.D., Board Certified in Orthopedic Surgery and Spinal 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)

The reviewer finds that medical necessity exists for LESI with Fluoroscopy @ L3-4. The reviewer finds that medical necessity does not exist for Lumbar Myelogram w/CT.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines

8/10/10, 9/2/10

M.D., 7/24/00 - 8/19/10

PCS 12/12/08

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who has had a remote lumbar fusion at L4/L5 and L5/S1 and has had previous imaging studies including a myelogram, which reveals bulging disc at L3/L4. The patient is stated to have radiculopathy, particularly affecting the right leg with weakness and numbness. The patient had L3/L4 epidural steroid injection six months previously, which gave the patient great relief. Current request is for lumbar epidural steroid injection at L3/L4 and a lumbar myelogram post CT scan.

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

This is a patient who has a radiculopathy that was improved by the first lumbar epidural steroid injection at L3/L4. The ODG would support the use of a second epidural steroid injection in this circumstance where there are, according to the medical records, clear-cut radicular complaints. As far as the myelogram with CT is concerned, the ODG Guidelines

would not support a CT myelogram when other imaging studies such as MRI scan are available. There is no explanation from the requesting physician as to why myelography in this particular situation would be preferable to MRI scan. Certainly, given the date of the performed surgery, more likely than not the hardware implanted was titanium and, hence, there would be no additional benefit to obtaining a CT myelogram over an MRI scan. It is for this reason the previous adverse determination has been partially overturned and partially upheld. The reviewer finds that medical necessity exists for LESI with Fluoroscopy @ L3-4. The reviewer finds that medical necessity does not exist for Lumbar Myelogram w/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)