

SENT VIA EMAIL OR FAX ON
Oct/15/2010

True Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (214) 717-4260
Fax: (214) 276-1904
Email: rm@trueresolutionsinc.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/15/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Myelogram with CT

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 9/16/10 and 9/24/10

Dr. 9/1/10 thru 9/30/10

MRI 6/29/10

Unknown Doctor 7/7/10 and ???/??/??

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female (although elsewhere it states male). She is diagnosed with lumbar radiculopathy. She complains of low back pain with bilateral leg pain, right greater than the left. There is numbness and burning in the right leg. She has undergone physical therapy and ESIs. Her neurological examination reveals decreased left quadriceps and dorsiflexion strength, with bilateral extensor hallucis weakness. There is hypesthesia over the right shin and lateral right foot, diminished reflexes at the left knee and absent ankle reflexes bilaterally. An MRI of the lumbar spine 05/29/2010 reveals a 6mm spondylolisthesis and an L4-L5 disc protrusion with facet hypertrophy with severe stenosis; there is mild facet hypertrophy at L3-L4. The provider is requesting a myelogram with CT; he believes she is a surgical candidate, and this is being requested for surgical 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 may be performed "for preoperative planning and problem solving". The provider is planning on a surgical procedure, and this seems appropriate, given the symptoms, failure of conservative measures, findings on examination, and findings on MRI. Therefore, based on the submitted documentation the CT myelogram is medically necessary.

References/Guidelines

2010 *Official Disability Guidelines*, 15th edition
"Low Back" chapter

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)