

SENT VIA EMAIL OR FAX ON
Oct/05/2010

Independent Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (817) 349-6420
Fax: (817) 549-0311

Email: rm@independentresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/05/2010

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 Orthopedic Surgeon

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
MRI Lumbar Spine, 03/04/10
Office Visits, Dr., 04/12/10, 05/24/10, 07/12/10
Procedure Note, 06/15/10
Note requesting reconsideration, Dr., 08/19/10
Electrodiagnostic Studies, Dr., 08/20/10
Physical Therapy Initial Evaluation, 08/23/10
Reviews, 08/24/10, 09/16/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a injured his back while picking up a drum on xx/xx/xx. He reportedly treated with therapy. A lumbar MRI on 03/04/10 revealed mild congenital spinal stenosis, most prominent at L3-4 with mild superimposed facet hypertrophy. Dr. saw the claimant on 04/12/10. He was taking Skelaxin and Ibuprofen. His gait was left Trendelenburg. Strength, sensory and reflexes were normal. Congenital stenosis, degenerative disc and joint disease lumbosacral spine, lateral recess stenosis L3-4, L4-5 and facet hypertrophy L3-4, L4-5 were diagnosed. Facet injections at L3-4, continue medications, add Tramadol and a TLSO brace were recommended. On 06/15/10 lumbar facet injections bilateral L3-4 were administered. At the 07/12/10 follow-up it was noted that the injections helped for a couple days, then his symptoms returned. He had completed therapy. The examination was normal except for 3+ upper and lower extremity reflexes. EMG studies, impairment evaluation and a CT myelogram for surgical planning were recommended.

Reportedly the CT myelogram was denied on 07/19/10. Dr. reportedly saw the claimant for an impairment rating on 08/11/10 at which time he had limited lumbar motion, difficulty walking on the right toe to 4+/5 and a positive seated straight leg raise and supine producing low back and right leg pain. Dr. requested reconsideration on 08/19/10. The claimant presented to Dr. on 08/20/10 for electrodiagnostic studies. The physical examination that day was normal. The electrodiagnostic studies were normal. The myelogram was denied on two

reviews 08/24/10 and 09/16/10.

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

It is unclear what additional information lumbar myelogram would provide have in caring for this male who has already had an MRI on 03/04/10. There is no mention if this was a suboptimal study or if something else is being considered in the evaluation. There is no surgery documented on the medical records. Based upon this, a lumbar myelogram is not necessary and indicated.

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, (i.e. Low Back-Myelography)

Recommended as an option. Myelography OK if MRI unavailable

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)