

# US Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Sep/27/2010

**IRO CASE #:**

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

Cervical Myelogram with post CT scan and Lumbar myelogram with post CT scan

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

M.D., Board Certified Orthopaedic Surgeon  
American Board of Orthopaedic 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 Low Back – Lumbar & Thoracic and Neck and Upper Back

7/19/10, 8/18/10

M.D. 1/13/10, 2/8/10, 5/29/10, 7/2/10, 7/31/10, 8/6/10

Solutions 2/26/10

Solutions 4/15/10, 4/21/10

6/29/10

Diagnostic 1/15/08

**PATIENT CLINICAL HISTORY SUMMARY**

This is a female patient with a date of birth of xx/xx/xx and an injury date of xx/xx/xx. Records from 2010 state she has pain and problems with her knees, lumbosacral spine, cervical spine and both shoulders. She has had surgery on both knees in 2009. There was stated to be some numbness associated with the C6 dermatome, though the physical examination is cursory. There is no evidence of neurologic deficit in the lumbar spine within the medical records. The patient's cervical MRI scan, which was available for review, did not show any neural foraminal stenosis or nerve root compression. Current request is for cervical and lumbar myelogram with post myelographic CT scan to evaluate whether the previous bulges have increased in size. There is no rationale given within the records for the lumbar myelogram with post myelographic CT scan. The provider has written that the cervical myelogram and post CT scan are necessary to evaluate the cervical discs.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS**

#### **AND CONCLUSIONS USED TO SUPPORT THE DECISION**

Based on the Official Disability Guidelines and Treatment Guidelines, the indication for a myelogram with post myelographic CT scan is when MRI scan is unavailable or contraindicated. MRI scan has essentially displaced myelography and CT scan for evaluation of the spine. In this case the rationale for the cervical myelogram with post CT scan appears to be that the cervical MRI scan was negative. The provider has requested the study to evaluate if the cervical discs have increased in size since the last MRI in 2008. Exam note dated 8/6/10 states that a further MRI would elucidate whether the bulges noted previously have increased or not.

The request for Cervical Myelogram with post CT scan is not medically necessary. In addition, there is no absolutely no rationale given for the request for lumbar myelogram post CT scan. Based upon the records submitted and the ODG, the previous adverse determination cannot be overturned. The requesting physician has not given this reviewer sufficient reasons why the Official Disability Guidelines and Treatment Guidelines should be set aside in this particular case. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld. The reviewer finds there is no medical necessity in this case for Cervical Myelogram with post CT scan and Lumbar myelogram with post CT scan.

#### **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)