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Notice of Independent Review Decision

DATE OF REVIEW: 04/05/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar myelogram with post myelogram CT scan

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

Board Certified in Orthopedic 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Lumbar myelogram with post myelogram CT scan - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with D.O. and D.O. dated 09/27/10, 10/05/10, 10/14/10, 10/25/10, 11/02/10, 11/11/10, 11/22/10, 12/10/10, 12/21/10, and 12/30/10

An MRI of the lumbar spine interpreted by M.D. dated 11/04/10

An EMG/NCV study interpreted by M.D. dated 11/04/10

An evaluation with M.D. dated 12/01/10

An evaluation with M.D. dated 12/14/10

A DWC-73 form from Dr. dated 12/21/10

A request for authorization of a CT myelogram from Dr. dated 12/30/10

A letter of non-certification, according to the Official Disability Guidelines (ODG), from D.O. dated 01/04/11

An evaluation with P.A.-C. for Dr. dated 01/14/11

Evaluations with an unknown provider (signature was illegible) dated 01/19/11, 02/15/11 and 03/17/11

DWC-73 form from M.D. dated 01/19/11, 02/15/11, and 03/17/11

A letter of non-certification, according to the ODG, from M.D. dated 02/02/11

The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

On 09/27/10, Dr. recommended physical therapy, Skelaxin, a Medrol Dosepak, steroid injections, and a left ankle sleeve. Physical therapy was performed in October and November 2010. An MRI of the lumbar spine interpreted by Dr. on 11/04/10 showed right L3 neural foraminal stenosis related to a 2 mm. disc protrusion and a right endplate spur and disc bulging at L4-L5. An EMG/NCV study interpreted by Dr. on 11/04/10 showed evidence of left L5 radiculopathy and right L3 and/or S1 nerve root injury. On 12/14/10, Dr. recommended a lumbar CT myelogram. On 12/30/10, Dr. wrote a request for authorization of a CT myelogram. On 01/04/11, Dr. wrote a letter of non-certification for a lumbar myelogram CT scan. On 01/14/11, Ms. recommended a CT myelogram, Motrin, and right ankle brace. On 02/02/11, Dr. wrote a letter of non-certification for a lumbar myelogram CT scan. On 02/15/11, the unknown provider recommended an aircast, Hydrocodone, Gabapentin, and a right wrist MRI. On 03/17/11, Dr. kept the patient off work through 04/12/11.

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

The ODG notes that CT myelography is okay if an MRI is unavailable, contraindicated, or inconclusive. It appears the claimant's MRI findings were conclusive. The ODG also states that invasive evaluation by means of myelography and computed tomography myelography may be supplemental when visualization of neural structures is necessary for surgical planning, which is also not the case with this patient. It is unlikely that any further information would be achieved by obtaining a CT myelogram at this time. While there is a mismatch between the findings on the electrodiagnostic study and the MRI, this is not sufficient objective evidence to obtain a CT myelogram, an invasive study

with a known complication rate. Based upon the criteria in the ODG, the requested lumbar myelogram with post myelogram CT scan is neither reasonable nor necessary. The previous adverse determinations should be upheld at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)