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Notice of Independent Review Decision

Reviewer's Report

DATE OF REVIEW: March 25, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Myelography, lumbosacral, radiological supervision and interpretation.

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

M.D., Board Certified in Orthopedic Surgery.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

[ ] Upheld (Agree)

[X] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

The requested service, myelography, lumbosacral, radiological supervision and interpretation, is medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 3/4/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 3/4/11.
3. Notice to IRO of Case Assignment dated 3/7/11.

4. Medical record from MD dated 1/26/11.
5. Letter from MD dated 1/31/11.
6. Medical evaluation completed by MD dated 7/9/10.
7. Denial documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a XX-year-old female who sustained an on-the-job injury on XX/XX/XX while lifting a trash bag. She has experienced low back and right leg pain since the injury. Conservative treatment has included chiropractic care and passive physical therapy without improvement. By report, a lumbar MRI performed on X/XX/XX revealed small to moderate broad-based central disc protrusion at L5-S1 and probable herniation with minimal extrusion. An MRI dated 1/18/10 revealed a right paracentral annular tear and a 3 mm disc substance protrusion/herniation minimally indenting the thecal sac with associated drying or desiccation of the disc substance at L4-5 and a left paracentral annular tear that indents the thecal sac in a mild degree at L5-S1. The patient's pain level was documented as 9 out of 10. In January 2011, the patient's provider recommended surgical planning. Authorization has been requested for myelography, lumbosacral, radiological supervision and interpretation (herein referred to as "lumbar myelogram/CT scan").

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

Review of the submitted clinical documentation demonstrates that the proposed lumbar myelogram/CT scan has been recommended for surgical planning. Specifically, the patient's provider ordered the lumbar myelogram/CT scan to look for any nerve root impingement. According to the Official Disability Guidelines (ODG), lumbar myelogram/CT scan is recommended if MRI is unavailable, contraindicated or inconclusive. ODG further states that lumbar myelogram/CT scan may be supplemental when visualization of neural structures is required for surgical planning. Additionally, the use of lumbar myelogram/CT scan for surgical planning is also an accepted indication according to the American College of Radiology (ACR) Practice Guidelines. All told, the use of lumbar myelogram/CT scan in this particular setting is consistent with ODG and ACR practice guidelines and is medically indicated and appropriate. Therefore, I have determined that the requested service is medically necessary for treatment of the patient's condition.

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

[X] 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

[**X**] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

ACR-ASNR PRACTICE GUIDELINE FOR THE PERFORMANCE OF MYELOGRAPHY AND CISTERNOGRAPHY. REVISED 2008.

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)