

I-Resolutions Inc.

An Independent Review Organization
8836 Colberg Dr.
Austin, TX 78749
Phone: (512) 782-4415
Fax: (512) 233-5110
Email: manager@i-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Aug/21/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CT Myelogram of the Lumbar Spine

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

MD, Board Certified 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Comprehensive Solutions, 7/14/11, 7/27/11

Official Disability Guidelines and Treatment Guidelines

Follow-up status reports dated 08/25/10-06/10/11

MRI lumbar spine without contrast dated 09/08/10

Rush Peer review dated 09/15/10

Physical therapy daily notes, 2010

Imaging consultation dated 09/22/10

Clinical records 10/11/10-05/23/11

Prospective / concurrent review determination PT 3x2 dated 10/06/10

Functional capacity evaluation dated 10/13/10

EMG/NCV dated 10/20/10

Prospective / concurrent review determination PT 6 sessions 3x2 dated 11/10/10

Procedure note lumbar epidural steroid injection L5-S1 and epidurogram dated 12/03/10

Psychological evaluation dated 12/13/10

Physical performance evaluation dated 01/04/11

Procedure note lumbar epidural steroid injection L5-S1 and epidurogram dated 01/19/11

Report of medical evaluation dated 01/20/11

Psychological evaluation dated 02/22/11

Report of medical evaluation dated 04/25/11

Report of medical evaluation dated 05/03/11

Procedure report lumbar epidural steroid injection L5-S1 and epidurogram dated 05/06/11

Prospective / concurrent review determination for CT myelogram of the lumbar spine dated 07/14/11

Letter of medical necessity dated 07/19/11

Prospective / concurrent review determination for appeal request CT myelogram of lumbar

spine dated 07/27/11

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a male who was injured on xx/xx/xx when he picked up and moved a 12-foot ladder. Records indicate he felt light discomfort in low back that day which progressively worsened. MRI of lumbar spine dated 09/08/10 reported 2 mm disc protrusion at L3-4 with no canal stenosis or foraminal encroachment. At L4-5 there is a 1 mm disc protrusion with no canal stenosis or foraminal encroachment. At L5-S1 there is loss of disc height and surrounding Mobic type I endplate edema present with broad 2 mm disc protrusion with 4 mm left paracentral component causing left S1 nerve root impingement and posterior displacement.

No canal stenosis or foraminal encroachment was appreciated. Electrodiagnostic testing was performed on 10/20/10 and reported evidence of L4, L5 and S1 radiculopathy. The injured employee was treated conservatively with physical therapy and epidural steroid injections which failed to relieve his symptoms. It was indicated the injured employee would benefit from L5-S1 left laminectomy, but a CT myelogram was recommended to get a closer look at L4-5 and L3-4 levels.

A preauthorization request for CT myelogram of lumbar spine was denied. The claimant has had lumbar MRI. Physical examination on 06/10/11 indicated the claimant with low back pain and left leg pain. Medications were listed as Naproxen and Flexeril. Left leg-gastrocsoleus – MS 4/5. Decreased sensation in S1 dermatome. Straight leg raise was negative. Since claimant has had lumbar MRI, and CT myelogram is not recommended by ODG if MRI is available. An appeal request for CT myelogram of the lumbar spine was denied as there was no additional objective clinical information provided upon which to base overturning the previous adverse determination.

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

This injured employee injured his lower back lifting a 12-foot ladder on xx/xx/xx. He was treated conservatively with physical therapy and epidural steroid injections without significant improvement. The injured employee underwent diagnostic testing with MRI and EMG/NCV. Per Official Disability Guidelines, CT myelogram may be indicated for lumbar spine if MRI is unavailable, contraindicated or inconclusive. There is no evidence that any of the ODG criteria is met in this case. There is no medical necessity for CT Myelogram of the Lumbar Spine.

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)