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## **Notice of Independent Review Decision**

**DATE OF REVIEW:** 01/19/11

**IRO CASE #:**

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

Lumbar myelogram with 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 CT scan - Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

An MRI of the lumbar spine interpreted by M.D. dated 09/11/09  
An evaluation with M.D. dated 11/11/10  
A letter of non-authorization for a CT myelogram, according to the Official Disability Guidelines (ODG), from M.D. dated 11/24/10  
A letter from Dr. dated 12/06/10  
A preauthorization request from Dr. dated 12/09/10  
A letter of non-authorization, according to the ODG, from D.O. dated 12/15/10  
The ODG Guidelines were not provided by the carrier or the URA

### **PATIENT CLINICAL HISTORY**

An MRI of the lumbar spine interpreted by Dr. on 09/11/09 showed a previous surgery at L5, a soft tissue density at L5-S1 and a disc protrusion at L2-L3. On 11/11/10, Dr. recommended a lumbar myelogram CT scan and possible spinal cord stimulator. On 11/24/10, Dr. wrote a letter of non-authorization for a CT myelogram. On 12/09/10, Dr. provided a preauthorization request for a CT myelogram. On 12/15/10, Dr. also wrote a letter of non-authorization for the CT myelogram.

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

The MRI of the lumbar spine obtained on 09/11/09 is diagnostic. It demonstrates previous surgery at the L5 level. It demonstrates congenital changes at the L2-L3 and L3-L4 level. The ODG does endorse CT myelography when an MRI is not obtainable; however, the MRI has been obtained. The CT myelogram will not provide any additional information or objective findings the MRI did not show. There also does not appear to be any objective changes in the claimant's status to warrant additional diagnostic studies, such as a CT myelogram based on the documentation. Based upon the fact that the patient does not meet the ODG criteria, the requested lumbar myelogram with CT scan is neither reasonable nor necessary and the previous adverse determinations should be upheld.

### **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 AND KNOWLEDGE BASE**
  
- 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)