

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jan/21/2011

**IRO CASE #:**

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

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**  
M.D., Board Certified Orthopedic Surgeon

**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**

08/24/10 MRI lumbar spine report  
09/01/10 electromyography report  
Records of MD, 09/15/10, 10/18/10, 11/02/10  
10/20/10 physical therapy  
Dr. office notes 11/10/10, 12/03/10  
Peer reviews 11/18/10, 12/14/10  
12/23/10 office note  
Official Disability Guidelines

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male with a date of injury of xx/xx/xx when he fell and injured his back and leg. The MRI of the lumbar spine from 08/24/10 showed moderate left and mild right L5 neural foraminal narrowing related to endplate spur and a small-superimposed far left paracentral disc protrusion with annular fissuring and 2 millimeter disc bulging at the L3-4 level without significant neural encroachment. The 09/01/10 electromyography suggested electrodiagnostic evidence of right L5 radiculopathy. On 10/18/10, the claimant underwent a right L4-5 and L5-S1 transforaminal epidural steroid injection. On 11/02/10, the claimant reported minimal pain relief of right lower extremity with numbness on top of the foot after the injection. Dr. evaluated the claimant on 11/10/10 for low back pain and right lower extremity pain. The claimant noted the injections did not help, the pain medication helped somewhat and physical therapy provided no improvement. Examination revealed increased overall thoracic kyphosis, diffuse non-focal tenderness and limited range of motion primarily in extension, lower extremities strength 4+/5 in all groups. Reflexes were absent at patella and

Achilles. Straight leg raise was negative. Dr. reviewed the MRI from 08/24/10. Diagnosis was right lumbar radicular pain, previously operated lumbar spine, unremarkable EMG and NCS for an acute radiculopathic process. Dr. evaluated the claimant on 12/03/10. Exam was not changed. A CT myelogram was recommended.

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

The request is for lumbar CT myelogram. The date of injury was xx/xx/xxx. The claimant had an MRI of the lumbar spine on 08/24/10 which showed moderate left and mild right L5 neural foraminal narrowing related to end plate spurring as well as a small superimposed far left paracentral protrusion. The EMG's were felt to be suggestive of right L5 radiculopathy. The claimant underwent epidural steroid injections. The claimant has had ongoing complaints of back and leg pain with weakness rather diffusely. Straight leg raising was negative. The claimant's subjective complaints appear to be out of proportion to the MRI. A lumbar CT myelogram was recommended. In light of the ongoing chronic leg pain, the CT myelogram is medically necessary. The CT myelograms do show better bony detail and they help determine if there is new impingement due to a bony source. They are not exclusive of MRI's but are complimentary to. In light of this individual's ongoing complaint of pain, the reviewer finds that CT myelogram is medically necessary.

**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)