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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: July 14, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

CT myelogram lumbar spine.

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, CT myelogram of the lumbar spine, 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 6/14/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 6/23/11.
3. Notice of Assignment of Independent Review Organization dated 6/24/11.

4. Letter from patient dated 6/13/11.
5. Office Note from The Minimally Invasive Spine Institute dated 11/18/10.
6. CT Scan of T-Spine w/out Contrast dated 1/4/11.
7. Office Note from DO dated 4/15/11.
8. Progress note dated 2/17/11 (unsigned).
9. OP Lumbar Spine 3 Views dated 10/16/09.
10. Operative Report from Medical Center dated 1/13/10.
11. Denial documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who has requested authorization for a lumbar spine CT myelogram. A review of the record indicates the patient sustained an on-the-job injury on xx/xx/xx. He has been diagnosed with post laminectomy pain syndrome. He is status post placement of a spinal cord stimulator in 2006 which was replaced in January 2010. The patient reports the stimulator is not relieving his pain. X-rays of the lumbar spine showed overall stable appearance of the lumbar spine. The patient has paresthesias in the left lower extremity and leg weakness. In addition, urological symptoms are present with pain in the area of the generator. The patient's provider has requested a CT myelogram prior to removal of the stimulator to make sure there is not any significant scar formation or other significant pathology. The URA indicates the requested service is not medically necessary for treatment of the patient's medical condition.

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

A request has been made for CT myelogram of the lumbar spine for further evaluation prior to a planned surgical procedure. The Carrier indicates the patient does not meet Official Disability Guidelines (ODG) for a CT myelogram. However, ODG guidelines do not directly address this situation. In this particular case, the patient has a spinal implant that is no longer providing relief. Surgical removal of the patient's implant is planned; pre-operative testing is required prior to proceeding with surgical intervention to help guide the surgeon. A pre-surgical MRI cannot be performed in this case due to the presence of the implant. As such, a CT myelogram is medically necessary in this setting and is consistent with appropriate standards of surgical care. ODG is a pre-surgical guideline and applies in cases in which the decision to proceed with surgery is being considered. In this case, the decision to remove the implant has already been made and the requested service has been ordered to guide the surgeon.

For the reasons set forth above, I have determined that the requested CT myelogram of the lumbar spine is medically necessary for treatment of the patient's medical 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

[X] 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 (Do not address this specific situation)

[ ] 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)

[X] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
Villavicencio, A., et al. Elements of the Pre-operative Workup, Case Examples. *American Academy of Pain Medicine*, 2006;7(S1).