

MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: July 22, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar myelogram with post myelogram CT.

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)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

The requested service, lumbar myelogram with post myelogram CT, 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 6/30/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 7/5/11.
3. Notice of Assignment of Independent Review Organization dated 7/5/11.
4. Medical records from MD dated 12/30/09 and 3/31/11.
5. Operative Report from Hospital dated 5/18/10.
6. Letter from MD, dated 4/18/11.
7. Designated Doctor's Evaluation and Report dated 11/17/10.
8. Report of Medical Evaluation dated 10/22/10.
9. Re-examination from DC dated 12/20/10.
10. MRI of the Lumbar Spine with Contrast dated 11/12/10.
11. MRI of the Lumbar Spine with Contrast dated 12/18/10.
12. MRI of the Lumbar Spine dated 6/4/09.
13. Lumbar Myelogram and CT dated 12/29/09.
14. Denial Documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an on-the-job injury on xx/xx/xx when he fell off of a ladder. He is status post L5-S1 microdiscectomy on 5/18/10. He now has recurrent back and leg pain that is similar to his pre-surgical symptoms. His use of pain medication has increased. Physical therapy was completed in July 2010. An MRI scan was performed on 12/8/10, which revealed recurrent disc herniation, right L5-S1 with extension into the right L5-S1 and neuroforamen with right foraminal stenosis. The patient has failed transforaminal epidural steroid. Conflicting physical findings have been identified; specifically, the patient's treating surgeon states the patient has pain on the right but has EHL (extensor hallucis longus) weakness and decreased Achilles reflex on the left. A lumbar myelogram with post myelogram CT has been requested by the surgeon but denied by the Carrier as not medically necessary.

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

According to Official Disability Guidelines (ODG), CT myelography is acceptable if an MRI is unavailable, contraindicated (e.g. metallic foreign body), or inconclusive. Per ODG, invasive evaluation by means of myelography and computed tomography myelography may be supplemental when visualization of neural structures is required for surgical planning or other specific problem solving. In the case of this patient, his treating surgeon has documented that the patient's MRI results are inconclusive and therefore a lumbar myelogram with post myelogram CT is needed. The proposed service has been recommended for decision-making purposes by the

treating surgeon in light of inconclusive MRI findings. As such, the requested service is consistent with ODG guidelines and is medically necessary to guide this patient's care.

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
- 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)