

Notice of Independent Review Decision

**REVIEWER'S REPORT**

**DATE OF REVIEW:** 03/13/11

**IRO CASE #:**

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

CT scan, cervical with contrast, cervical myelogram with 3D rendering interpretation and report, CT MRI scan ultrasound fluoroscopic guidance and localization (similar request for lumbar myelogram with CT scan)

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., F.A.C.S., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patient suffering lumbar spine problems

**REVIEW OUTCOME:**

Upon independent review, I find that the previous adverse determination or determinations should be:

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

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
847.0	72126		Prosp.						Upheld
847.2	72240		Prosp.						Upheld
847.3	76376		Prosp.						Upheld
924.11	77003		Prosp.						Upheld

**INFORMATION PROVIDED FOR REVIEW:**

1. Case assignment
2. Letters of denial 01/14/11 & 02/07/11, including criteria used in the denial.
3. Reports from the neurosurgeon 12/05/08, 12/19/08, 04/24/08, 06/10/09, 01/30/09, 01/19/09 & 11/30/10.
4. Treating doctor's correspondence (not dated), and evaluation 09/18/10.
5. Radiology reports 04/06/06, 12/28/07, 05/22/08 & 01/05/11.
6. Discharge notes 05/01/09, 05/12/09, 06/08/09, 06/17/09 & 07/16/09.
7. Rehabilitation consultation 02/07/08.
8. Operative report 12/10/08.
9. Evaluation 06/24/08.
10. Pain management progress note 09/23/08.
11. Correspondence from physician (evaluation) dated 08/15/08. Physician's specialty not identified.

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The injured employee is a male who was involved in a motor vehicle accident. He suffered lumbar spine pain and radicular pain resulting in an initial surgical procedure performed in 2006. The exact date of the surgical procedure is not provided in the medical records. Subsequently, owing to additional and persistent pain, he underwent a second surgical procedure in 2008 consisting of lumbar fusion with posterior instrumentation with removal of prior hardware and foraminotomies at L4/L5 and L5/S1. He has had persistent low back pain and persistent neurological findings consisting of diminished reflexes and some weakness. There is a non-dermatomal distribution of sensory deficits. He has had persistent low back pain and leg pain in spite of the prior surgical procedures. There has been a request made for repeat lumbar spine myelogram with CT scan and fluoroscopic guidance. There is some confusion as to the CPT codes submitted relating to cervical myelogram. However, all of the clinical records request lumbar myelogram. The request has been considered and denied, reconsidered and denied.

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

The patient has had persistent chronic back pain symptoms with chronic radiculopathy in spite of two lumbar surgical procedures and instrumented fusion from L3 through S1. The injured employee does not appear to be a candidate for current surgery. Repeat lumbar myelogram is not indicated. The prior denials were appropriate and should be upheld.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).