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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/23/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Myelogram Low back 72265 and Post Lumbar Myelogram CT Scan Low Back 72132

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

MD, 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

Official Disability Guidelines Treatment in Workers' Compensation,
Chapter: Low Back, CT & CT Myelography (computed tomography)

Dr. OVs, 01/16/08, 01/28/08, 02/04/08, 10/18/10

Dr. Medical record review, 01/10/11

Dr., OV 01/25/11

Dr. letter 02/08/10

Peer Reviews, 02/02/11, 02/21/11

Letter from claimant 03/14/11

MD pre-cert request form undated

PATIENT CLINICAL HISTORY SUMMARY

This is a male claimant with a low back injury reported in xxxx followed by a left lumbar hemilaminectomy and discectomy L5- S1 in April 1997. The records indicated that the claimant did well following surgery until the symptoms returned in 2007. The claimant was diagnosed with postlaminectomy syndrome and spondylolisthesis of L4-5 and degenerative disc disease.

An evaluation dated 01/25/11 noted the claimant with persistent low back pain despite conservative care, which included injections. Review of a lumbar CT scan of 2008 showed spondylolisthesis at L4-5 with some stenosis. Surgery was discussed and updated studies were recommended. A lumbar myelogram low back and post lumbar myelogram CT low back were requested. The records indicated that the claimant was not able to undergo an MRI because of having a pacemaker.

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

The claimant is unable to obtain an MRI, due to a pacemaker. He has undergone prior surgery, in 1997 consisting of L5-S1 discectomy. The records reflect that he did well until the symptoms returned in 2007. He was diagnosed with a post laminectomy syndrome and L4-5 spondylolisthesis. A note dated 01/25/11 makes reference to persistent back pain, but more importantly leg symptoms. It was noted that he had failed conservative treatment including injections and chiropractic care. In light of the leg symptoms and failure to respond to conservative treatment, the lumbar CT myelogram would be medically necessary to rule out neurocompressive etiology for the leg pain and to determine if the claimant is a candidate for surgical intervention. ODG recommends CT myelography in cases such as this where MRI is not available and the provider has given a clear rationale for the study. The reviewer finds there is medical necessity for Lumbar Myelogram Low back 72265 and Post Lumbar Myelogram CT Scan Low Back 72132.

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 KNOWLEDGBASE

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)