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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/14/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
CT myelogram of the lumbar spine

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

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Official Disability Guidelines Treatment in Worker's Compensation, Chapter: Low Back, CT & CT Meylography
Denial letters 2/1/11, 2/11/11
Clinic 3/16/10 to 1/26/11
Clinic 4/27/10
MRI 8/25/09 to 9/8/10
Clinic 8/12/09
MD 10/20/09
MD, LTD 5/19/09 to 9/7/10
Physical Therapy Records 1/22/09 to 2/23/09
Clinic4/14/10
Clinic no date
Provider 5/25/10 to 6/7/10
MD 10/13/09
Clinic 12/23/10

PATIENT CLINICAL HISTORY SUMMARY
This is a XX year-old female who was injured on XX/XX/XX when catching an object that fell from an overhead storage area. She has had a previous lumbar spine laminectomy at L5/S1, and MRI scan showed disc desiccation at L5/S1. There is documentation of persistent low back pain and leg pain and some weakness of the foot. A decision has already been made that she requires a single level fusion at L5/S1. She has had four epidural steroid injections with little effect and some nerve blocks. An EMG showed some radiculopathy, and the MRI scan revealed some disc desiccation at L5/S1 with some retrolisthesis of 2-3 mm and posterior disc protrusion at L5/S1 without contact with the roots. We did not note

documentation of instability by flexion/extension films. Current request is for CT myelogram with post CT scan.

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

Given the fact that the patient has already been documented to be a surgical candidate at L5/S1, the rationale for this request of further imaging is unclear. If the determination has already been made that she needs surgery, it is unclear why the myelogram with post CT scan would still be necessary. This has not been explained in the medical records.

Furthermore, as the previous reviewer has noted, this patient does not meet Official Disability Guidelines and Treatment Guidelines for the use of a CT myelography, which would include spinal trauma, myelopathy, and possible evaluation post surgical fusion. Given the absence of necessity to establish diagnosis and treatment plan, the absence of the provider's rationale for the CT myelogram and its non-concordance with the Official Disability Guidelines and Treatment Guidelines, the reviewer is unable to overturn the previous adverse determination. The reviewer finds no medical necessity for CT myelogram of the lumbar spine.

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

[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

[ ] 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)