

SENT VIA EMAIL OR FAX ON
May/03/2011

P-IRO Inc.

An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #203
Mansfield, TX 76063
Phone: (817) 405-0878
Fax: (214) 276-1787
Email: resolutions.manager@p-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/03/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar CT Myelogram

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

Texas MD: Board Certified 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a = male whose date of injury is xx/xx/xx. Records indicate the injured employee was injured when his chair he was sitting on collapsed. The injured employee was diagnosed with lumbar intervertebral disc without myelopathy. MRI of lumbar spine performed 06/23/10 revealed indeterminate 9 mm lesion in right side of L2 adjacent to pedicle; mild degenerative disc disease T12-L1 and L3-4; facet arthropathy in lower lumbar spine; transitional vertebral body at lumbosacral junction. Physical examination on 02/07/11 reported no structural deformity. Range of motion reported flexion to only 45 degrees. There was pain with straight leg raise on right at 30 degrees, negative on left. Motor strength was normal except some decreased strength in right gastrocnemius and gastrosoleus group. Right ankle reflex was absent. Electrodiagnostic testing performed on 09/13/10 reported findings consistent with diabetic polyneuropathy. The EMG report noted that clinically the etiology of bilateral leg pain remained unclear. Per notes dated 02/07/11, the injured employee had no specific objective evidence of lumbar radiculopathy versus diabetic neuropathy. The injured employee was recommended to undergo lumbar myelogram with post CT scan.

An initial preauthorization / UR determination by Dr. on 03/04/11 found that the request for lumbar CT myelogram was not recommended as medically necessary. It was noted the injured employee had undergone previous lumbar MRI, and there was no indication of a proposed surgical procedure that would require further imaging. Dr. noted that CT myelogram may be option if MRI is unavailable, contraindicated, or inconclusive.

An appeal preauth/UR determination on 04/08/11 by Dr. deemed the request for CT myelogram as not medically necessary. It was noted the injured employee underwent MRI which did not show an operative disc herniation. There was no indication of post surgical procedure that would require any further imaging. Dr. recommended an adverse determination.

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

The request for CT scan of lumbar spine without contrast (lumbar CT myelogram) is not supported as medically necessary. The injured employee is noted to have sustained an injury to low back on xx/xx/xx when the chair he was sitting in collapsed. Since that time the claimant complained of low back pain with radiation to right greater than left lower extremities. He was treated conservatively with therapy and medications. MRI performed on 06/23/10 revealed an indeterminate 9 mm lesion in right side of L2 adjacent to pedicle. At L3-4 there was disc desiccation and mild disc bulge as well as bilateral facet hypertrophy with no significant spinal canal narrowing, and mild bilateral foraminal narrowing. At L4-5 there is no disc herniation or spinal stenosis with mild bilateral facet hypertrophy and mild bilateral neural foraminal narrowing. At L5-S1 there was transitional vertebral body. Electrodiagnostic testing revealed no evidence of lumbar radiculopathy, noting findings consistent with diabetic polyneuropathy. ODG guidelines provided that lumbar myelogram CT may be indicated if MRI is unavailable, contraindicated, or inconclusive. None of these factors obtain in this case, and medical necessity is not established.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES