Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 05/10/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
CT Myelogram of the Lumbar Spine

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Board Certified in Orthopaedic Surgery
Certified in Evaluation of Disability and Impairment Rating -
American Academy of Disability Evaluating Physicians

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

CY Myelogram of the Lumbar Spine – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY (SUMMARY):

The patient who stated that he started noticing some increased pain in his lower back. He was involved in a work accident on xx/xx/xx, while working as a. He fell down a flight of stairs onto his back. The assessment was right-sided buttock and right leg pain with signs of a S1 radiculopathy with probable herniated nucleus pulposus at L5- S1. After therapy, an ESI was recommended. The original MRI was said to show a central and slightly right-sided herniated nucleus pulposus at L5-S1. A repeat MRI scan 02/10/11 demonstrated at L5-S1 a moderate loss of disc height and disc desiccation, with a broad-based 5-mm posterior central disc protrusion which mildly indented the ventral aspect of the thecal sac, without high-grade central spinal stenosis. There was no foraminal stenosis at that level but mild degenerative facet hypertrophy bilaterally was noted. On 02/15/11, Dr. noted that the herniation at L5-S1 was a "little bit worse than what he had before, which would account for his symptomatology". A myelogram CAT scan was ordered "to see if indeed there is compression of the right S1 nerve root" which Dr. did not feel was seen on the MRI. The CT myelogram was not pre-certified. There was no conclusive electrodiagnostic evidence of a right lumbosacral radiculopathy or a distal right lower extremity neuropathy.

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

The CT Myelogram of the lumbar spine is not medically reasonable and necessary. Although the MRI was "equivocal", it is unlikely the CT myelogram will demonstrate more definitive information. There is no evidence of indications for imaging: no thoracic spine trauma, lumbar spine trauma, chance fracture, myelopathy traumatic or infectious disease patient. There is no fusion to evaluate. Therefore the CT myelogram is not required.

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)**
- ☐ **AMA GUIDES 5TH EDITION**