

SENT VIA EMAIL OR FAX ON
Nov/11/2011

Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/10/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CT Myelogram Lumbar Spine

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

Board Certified Orthopedic Spine 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

OD Guidelines

Notification of determination 9/23/11

Utilization review determination 10/12/11

Worker's comp preauthorization and procedure order request

Office notes

Procedure note lumbar epidural steroid injection 07/18/11

MRI lumbar spine 05/25/11

medical records 05/27/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who was injured on xx/xx/xx. Records indicate he had a flat and hurt his back while trying to lift a heavy tire. MRI of lumbar spine dated 05/25/11 revealed multilevel degenerative changes with large left lateral disc protrusion / extrusion at L3-4 causing severe left neural foraminal stenosis. The claimant was treated conservatively with physical therapy and medications. An epidural steroid injection was performed on 07/18/11, but the claimant did not receive any relief whatsoever.

A preauthorization request for CT myelogram of lumbar spine was reviewed on 09/23/11 and determined to be non-certified as medically necessary. It was noted that documentation submitted for review elaborates the patient complaining of ongoing low back pain. The Official Disability Guidelines recommend CT myelogram provided the patient meets specific criteria to include MRI being unavailable or contraindicated. The documentation submitted

for review included MRI of lumbar region. Given the conclusive findings revealed on MRI, the request does not meet guideline recommendations and is not recommended as medically necessary.

An appeal request for CT myelogram of lumbar spine was reviewed on 10/12/11 and request was non-certified as not consistent with clinical review criteria. The records indicate there was prior non-certification given the conclusive findings revealed on MRI. There is also documentation the claimant is a male who sustained an injury xx/xx/xx. He experiences back pain with VAS score 5/10. On physical examination there is note of antalgic gait with limping on the left side, with motor weakness of left quadriceps muscles, diminished sensation on left, medial and anterior thigh, and positive straight leg raise on left. Conservative treatment includes medications, epidural steroid injection, and physical therapy. MRI of lumbar spine dated 05/25/11, radiologist analysis by revealed multilevel degenerative changes with large left lateral disc protrusion / extrusion at L3-4; no fracture or spondylolisthesis. However, there remains no documentation that MRI is unavailable, contraindicated, or inconclusive, and therefore, medical necessity of the request is not substantiated.

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

Based on the clinical information provided, the request for CT myelogram of lumbar spine is not supported as medically necessary, and previous denials are upheld. The claimant is noted to have sustained injury to low back when he lifted a heavy tire after having a flat. He was treated conservatively with medications, physical therapy, and epidural steroid injections. Records indicate epidural steroid injection provided no relief whatsoever. MRI of the lumbar spine was performed on 05/25/11 and noted multilevel degenerative changes, with a large left lateral disc protrusion / extrusion at L3-4 level. Physical examination findings were consistent with imaging studies. As noted on previous reviews, ODG guidelines reflect that CT myelogram is option if MRI is unavailable, inconclusive, or contraindicated. The claimant in this case does not meet any criteria as specified in Official Disability Guidelines Low Back Chapter. As such, the proposed CT myelogram of lumbar spine is not supported as medically necessary.

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