

SENT VIA EMAIL OR FAX ON
Nov/14/2011

Applied Assessments LLC

An Independent Review Organization
3005 South Lamar Blvd, Ste. D109 #410
Austin, TX 78704
Phone: (512) 772-1863
Fax: (512) 857-1245
Email: manager@applied-assessments.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/11/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient Lumbar Myelogram with CT

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

Orthopedic spine surgeon, practicing neurosurgeon

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 claimant is a female whose date of injury is xx/xx/xxxx. The claimant reports she was lifting up high and strained her back. She relates that she was reaching and fell onto her buttocks. The claimant has undergone extensive treatment including multiple epidural steroid injections and diagnostic/imaging studies. The claimant was seen in follow up on 09/22/11 and was noted to have increasingly severe bilateral lumbar pain and bilateral radiating hip and leg pain with numbness, dysesthesias and weakness in her legs. She walks with a flexed posture at the low back. Straight leg raising is positive bilaterally around 45 degrees. The claimant was noted to have done quite well from left total knee replacement. Norco was increased to 10 mg. She also takes Zanaflex and Celebrex. The claimant was recommended to undergo lumbar myelogram and post CT scan.

A utilization review determination dated 10/04/11 found the request for outpatient lumbar myelogram with CT to be non-certified as medically necessary. It was noted that the claimant sustained an injury on xx/xx/xx and has complaints of lumbar pain and bilateral radiating hip and leg pain with numbness. She had CT lumbar myelogram done on 11/12/08 and according to the documentation provided there was minimal evidence of significant change. The recent clinical notes have minimal evidence of neurological deficits upon physical examination. Therefore, request for lumbar myelogram with CT is non-certified.

A utilization review dated 10/12/11 determined that an appeal request for outpatient lumbar myelogram with CT was non-certified as medically necessary. The reviewer noted that records indicate there was an adverse determination of a previous review. In acknowledgement of the previous non-certification due to lack of documentation of significant change in neurological deficits on physical examination, there is now documentation as per 09/22/11 note the claimant complains of increasing severe bilateral lumbar pain, bilateral radiating hip pain and leg pain with numbness. Physical examination revealed positive SLR. Treatment has included medication, epidural steroid injection and physical therapy. However, there is no clear documentation of MRI unavailable, contraindicated (eg, metallic foreign body), or inconclusive, or CT myelogram used as a supplement when visualization of the neural structures is required for surgical planning or other specific problem-solving. Therefore medical necessity of the request has not been 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 outpatient lumbar myelogram with post CT is not indicated as medically necessary. The claimant is noted to have sustained an injury to the low back on xx/xx/xx. Treatment to date has included medications, epidural steroid injections and physical therapy. The claimant was noted to complain of increasing severe bilateral lumbar pain with bilateral radiating hip pain and leg pain with numbness. Examination on 09/22/11 reported straight leg raising is positive bilaterally. There is no assessment of motor, sensory or reflex function. CT myelogram performed 11/12/08 reported postoperative changes secondary to posterior lumbar interbody fusion procedure at L4-5 and L5-S1 with bilateral pedicle screws at L4, L5 and S1 transfixing posterior compression plates extending from L4 through S1. Interdisc spacers are present within the L4-5 and L5-S1 disc spaces. There is minimal spinal canal stenosis at L3-4. While it appears that the presence of retained instrumentation of the lumbar spine would preclude MRI due to metallic artifact, the lack of evidence of progressive neurologic deficit does not establish medical necessity for the proposed CT myelogram of the lumbar spine.

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