

SENT VIA EMAIL OR FAX ON
Oct/7/2011

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/13/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CT Myelo Lumbar

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

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 claimant is a female who was injured on xx/xx/xx while working. She felt intense pain in her low back and right shoulder area that radiating down the right lower extremity. The claimant received initial conservative treatment including x-rays, physical therapy and oral anti-inflammatory medications. MRI of lumbar spine performed on 03/23/10 revealed L4-5 9 mm ruptured disc central extends inferiorly still attached to disc; central canal stenosis moderately advanced; extension compression against exiting nerve root sleeves at L5 probably more on right than left. At L5-S1 there were Modic type II signal abnormalities noted with a 3 mm herniated disc primarily central. There is neural foraminal narrowing

slightly more on left than right that may minimally affect left S1 nerve root sleeve. Records indicate the claimant underwent lumbar laminectomy at L4-5 performed 10/27/10. The claimant subsequently underwent right shoulder arthroscopy performed on 02/09/11. The claimant participated in postoperative physical therapy. The claimant continued to complain of low back pain with occasional pain radiating down both lower extremities. Repeat MRI performed on 08/23/11 reported a 6 mm right paracentral disc herniation at L4-5 level that compresses the right anterior thecal sac and right exiting nerve root.

A preauthorization request for CT myelo lumbar spine was reviewed on 09/13/11 and was determined as not medically necessary. It was noted the claimant was taken to surgery on 10/27/10 where lumbar laminectomy, discectomy and foraminotomy at L4-5 was performed. The claimant evidently did well with low back until 04/11 when she reported increasing low back pain radiating into the right lower extremity. On physical examination motor strength was mildly weak into the right EHL. The claimant had mild subjective paresthesias along the bilateral L5 distribution. Reflexes remained blunted in both lower extremities than they were prior to 10/27/10. MRI performed on 08/23/11 showed a 6mm right paracentral disc herniation at the L4-5 level that compresses the right anterior thecal sac and right exiting nerve root. The claimant does not report any new trauma to the lumbar spine after the date of surgery. Medical records submitted do not indicate current plain imaging of the lumbar spine. However there is a known MRI which demonstrates disc at L4-5 compression of the anterior thecal sac and right exiting nerve root. This was noted as appropriate for the physical examination on 09/02/11 demonstrating paresthesias along the bilateral L5 distribution. Therefore the request for CT myelogram does not meet current criteria and the request is non-certified.

An appeal request for CT myelo lumbar was reviewed on 09/26/11 and again determined as not medically necessary. The reviewer noted that per 09/02/11 medical report that claimant complains of constant low back pain rated 7/10, discomfort with side to side movement, soreness and stiffness and occasional radiation down the lower extremities. Physical examination showed tenderness in mid to lower lumbar region with decreased range of motion, positive straight leg raise on the right, mildly weakened right extensor hallucis longus, mild paresthesias along the bilateral L5 distribution, and blunted reflexes in the lower extremities. Recent MRI revealed a 6mm right paracentral disc herniation. The medical information submitted for review does not indicate any presence of red flags or severe progressive neurologic deficits to warrant medical necessity of CT myelogram. Current guidelines optionally advocate the use of these studies only as surgical planning is warranted, in which clinical data in this particular case failed to clearly indicate. Failure of response to conservative treatment such as oral pharmacotherapy or rehabilitation was not objectively documented. Based on the foregoing medical necessity has not been established.

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

The clinical data submitted for review does not support a determination of medical necessity for proposed CT myelogram lumbar spine. Claimant sustained a lifting injury to the low back on xx/xx/xx. She subsequently underwent lumbar laminectomy discectomy at the L4-5 level as well as right shoulder arthroscopic surgery. Claimant apparently did well following surgery to the lumbar spine on 10/27/10 but subsequently developed low back pain with occasional radiation of pain into the lower extremities. Repeat MRI of the lumbar spine on 08/23/11 revealed a 6mm right paracentral disc herniation at the L4-5 level compressing the right anterior thecal sac and the right exiting nerve root. Per Official Disability Guidelines, CT myelography is not recommended, but may be okay if MRI is unavailable, contraindicated or inconclusive. Claimant had recent MRI performed on 08/23/11, and therefore MRI is not unavailable, contraindicated or inconclusive. As such the request is not consistent with Official Disability Guidelines criteria and not indicated as medically necessary.

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

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)