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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/19/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Myelogram

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

M.D., Board Certified Neurological 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

Official Disability Guidelines

Request for IRO dated 04/04/12

Utilization review determination dated 02/23/12

Utilization review determination dated 03/09/12

Clinical records 06/23/05-02/13/12

CT lumbar spine dated 07/06/11

CT myelogram of lumbar spine dated 06/16/10

CT lumbar spine dated 06/16/10

MRI lumbar spine dated 07/10/07

CT myelogram lumbar spine dated 09/15/05

Radiograph lumbar spine dated 06/14/05, Radiograph right hip dated 11/21/05

Operative report dated 08/17/05

Radiographic report lumbar spine dated 11/21/05

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained work related injuries on xx/xx/xx. Records indicate the claimant was refractory to conservative treatment. On 08/17/05 the claimant was taken to surgery and underwent L3-5 decompressive laminectomy with ALIF and posterolateral fusion with interbody cages at L3-4 and L4-5, pedicle screws, and rods. Postoperatively it does not appear as though the claimant had significant improvement. The record includes MRI of lumbar spine dated 07/10/07. This study notes multilevel degenerative disc disease and spondylosis with mild spinal stenosis at L2-3 and bilateral foraminal narrowing and right foraminal narrowing at L4-5 which possibly contacts right exiting nerve root. There are postoperative changes with mild enhancing scar in spinal canal. Records indicate the claimant was referred for CT myelogram of lumbar spine on 06/16/10. This study notes decompression, laminectomy and fusion from L3-5. There are bilateral pedicle screws at L3, L4 and L5 with vertical connecting rods and transverse bracket. Interbody spacers appear unchanged, and disc spaces are well maintained at L3-4 and L4-5. There is mild central canal stenosis at L2-3, which appears little changed since prior

myelogram. MRI of cervical spine was performed on 02/17/11 and reported multilevel spondylosis. There were no compression fractures. Clinical notes from note that the claimant has severe mid lumbar pain with radicular pain down both legs with numbness dysesthesias and weakness in the legs. The claimant walks with a flexed posture at the low back he has appropriate weakness in the quadriceps and foot and great toe plantar flexion and dorsiflexion. The claimant is noted to have an implanted pacemaker. Current medications include hydrocodone Flexeril and Motrin. requests CT myelogram for severe stenosis at L2-3 with progressive neurologic deficit and a severe chronic pain syndrome.

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

The claimant's complaints are chronic without evidence of a progressive neurologic deficit and serial CT myelograms indicate that the claimant's radiographic appearance is stable and was unchanged. The claimant has previously been identified as having stenosis at adjacent level disease L2-3. A repeat CT myelogram would not contribute to any future operative planning. In the absence of clear data establishing a new and progressive neurologic deficit, it is the opinion of the reviewer that the Lumbar Myelogram is not 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)