

C-IRO Inc.

An Independent Review Organization

1108 Lavaca, Suite 110-485

Austin, TX 78701

Phone: (512) 772-4390

Fax: (512) 519-7098

Email: resolutions.manager@ciro-site.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/20/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Myelogram with post CT scan Lumbar

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

M.D., 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. The reviewer finds the requested myelogram with post CT scan Lumbar is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Request for IRO 07/31/12

Utilization review determination 06/04/12

Utilization review determination 07/13/12

Utilization review determination 07/27/12

Carrier correspondence 07/16/12-07/30/12

Clinical note

Radiographic report lumbar spine 09/13/11

Radiographic report left knee 09/13/11

Clinical note

MRI lumbar spine 10/04/11

Clinical note

Chiropractic treatment notes 12/12/11-06/24/12

Clinical note

Pre-surgical psychological evaluation 02/17/12

Chart review

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who is reported to have sustained multiple injuries as a result of a slip and fall. The claimant was evaluated. The claimant is noted to have complaints of low back pain, left shoulder, elbow and knee pain. Radiographs were performed and no acute osseous abnormalities were identified in either the back or left knee. The claimant was referred for MRI of the lumbar spine on 10/04/11. This study notes a grade 1 anterolisthesis of L4 on L5 with a broad protrusion and severe facet arthropathy resulting in moderate spinal canal stenosis and mild foraminal narrowing. At L5-S1 there is no evidence of disc protrusion, mild facet arthropathy, central canal stenosis, or foraminal stenosis. On 11/22/10, she is noted to have pain in the back, left shoulder and left knee. Current medications include hydrocodone and Amitriptyline. She has decreased sensation in the left lower extremity in the L4-5 distribution with decreased motor function in the left lower extremity. She has

continued taking oral medications, advanced to physical therapy as tolerated and a lumbar epidural steroid injection was recommended. She had a protracted course of chiropractic treatment. The claimant was examined by Dr.. He reports that she has completed physical therapy without significant improvement. She reports her pain level to be 8/10, surgical history is non-contributory. She is reported to have 4/5 strength in the left tibialis anterior and EHL; otherwise 5/5 throughout. Deep tendon reflexes were 2+ and symmetric, there is difficulty with heel walking but less with toe walking. Straight leg raise is reported to be positive on the left at 60 degrees and negative on the right. There is decreased sensation in the left S1 distribution. Dr. reports a sacralized lumbar segment. Anterior lumbar interbody fusion with fixation at L4-5 was recommended. The record includes a pre-operative psychological evaluation dated 02/17/12. The claimant had minimal findings in terms of depression and anxiety and was cleared for surgical intervention. The record contains a letter from Dr. dated 05/02/12. He opines that the claimant is a potential surgical candidate with worsening symptomology; to differentiate between a laminectomy versus fusion surgery he recommends the performance of a dynamic CT myelogram.

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

This claimant has complaints of low back pain with radiation into her lower extremities. MRI of lumbar spine notes pathology at L4-5 level. This study clearly was an adequate study for surgical planning. There is no indication of any significant pathology or ambiguous pathology above or below this level. The claimant has had prior recommendations by a surgeon to undergo performance of fusion procedure at this level. The request for surgery was denied, however. Therefore, there would be no clinical indication for performance of CT myelogram for operative planning as the advised surgical procedure has not been approved. At present, the submitted clinical records provide no data to establish the claimant has progressive neurologic deficit, which would require reimaging. Therefore, based on the information provided, the reviewer finds the requested myelogram with post CT scan Lumbar is not medically necessary and does not meet ODG guidelines.

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)