

SENT VIA EMAIL OR FAX ON
Jan/17/2012

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/12/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Myelogram with CT Scan

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

Board Certified 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

OD Guidelines

Request for IRO dated 01/13/12

Utilization review determination dated 11/18/11

Utilization review determination dated 11/30/11

Clinical records Dr. dated 05/11/11-10/13/11

Procedure report epidural steroid injection dated 06/20/11

MRI lumbar spine dated 03/03/11

Physical therapy evaluation dated 08/19/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained work related injuries on xx/xx/xx. It is reported he was injured while using sledge hammer and fell off well head about 7-8 feet landing on his right hip and buttock area and lumbosacral spine. He is reported to have severe pain in lumbosacral region of both hips and legs primarily to the right. The claimant was referred for MRI of lumbar spine on 03/03/11. This study notes disc desiccation and

shallow disc protrusion at T12-L1. At L1-2 there is mild disc desiccation with shallow disc bulge and endplate spurring. There are mild degenerative changes of facet joint. At L2-3 there is disc desiccation with a minimum endplate spurring and minimum disc bulge. At L3-4 disc space there is disc desiccation with mild loss of disc height and retrolisthesis. There is pseudo listhesis with underlying endplate spondylosis, facet arthropathy, and ligamentum flavum hypertrophy contributing to mild central canal stenosis. There is biforaminal stenosis, mild bilaterally with abutment of exiting L3 nerve root particularly on the left. At L4-5 there is disc desiccation with loss of disc height and vacuum disc phenomenon. There is broad based spondylitic protrusion and moderate facet arthropathy with ligamentum flavum hypertrophy contributing to central canal stenosis, bilateral lateral recess stenosis contributing to abutment of bilateral descending L5 nerve roots. There is biforaminal stenosis mild bilaterally with abutment of exiting L4 nerve roots at neural foramina bilaterally particularly on the left. At L5-S1 there is a broad concentric protrusion with abutment of descending S1 nerve root particularly on right. In addition there is broad based disc bulge with compression of L5 nerve root bilaterally particularly on the right. There is evidence of bilateral narrowing due to hypertrophy of facet joint along with disc desiccation and loss of disc height. The claimant subsequently came under the care of Dr.. He is reported to be taking Hydrocodone, Flexeril, Meloxicam and Neurontin. He has had no physical therapy and has not improved. He is noted to be 5'8" 229 lbs. There is a loss of lumbar lordosis. He walks with flexed posture of low back. There is paralumbar muscle tightness. He has limited mobility in all planes. Deep tendon reflexes are 1+ in knees and trace in ankles. He has some decreased sensation over lateral aspect of distal right leg. He has a little weakness with plantar flexion and dorsiflexion of right foot. He subsequently was recommended to begin physical therapy and undergo lumbar epidural steroid injections. On 06/28/11 the claimant underwent lumbar epidural steroid injection at L5-S1 without any documented improvement. The claimant was subsequently seen in follow-up on 08/19/11 and reported to be status post arthroscopic shoulder procedure which included a subacromial decompression and distal clavicle resection as well as small rotator cuff repair. He subsequently was to begin postoperative physical therapy. The claimant was seen in follow-up by Dr. on 10/13/11 and continues to have back pain radiating into hip and leg mainly on the right. MRI is reported to show severe posttraumatic pathology at L4-5 and L5-S1. He is noted to have undergone extensive physical therapy without benefit. He had right L5-S1 epidural steroid injection which only provided minimal benefit. He has right antalgic gait. Straight leg raise is positive bilaterally. He is subsequently recommended to undergo lumbar myelogram and post myelogram CT.

Dr. performed the initial review on 11/18/11. Dr. non-certified the request noting there is no objective evidence of radiculopathy on physical examination. He notes myelogram would be supported when MRI cannot be performed. He reported the claimant has no documented changes on physical examination to support neural compromise to indicate need for repeat imaging at this time.

Dr. performed the subsequent appeal request on 11/30/11. Dr. upholds previous denial and non-certified the request. He notes the requesting provider states the myelogram will allow determination to proceed with surgery or further steroid injections. He noted there is no documentation of recent physical examination and indicated 03/03/11 lumbar MRI demonstrates disc bulges with root compression. There was no rationale provided for additional imaging.

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

The request for CT myelogram of lumbar spine is not supported by the submitted clinical information, and previous utilization review determinations are upheld. The record indicates the claimant sustained injuries to low back as result of fall from approximately 8 feet. The claimant has undergone MRI of lumbar spine which clearly shows multilevel pathology most prominent at L3-4, L4-5 and L5-S1. There are multilevel reports of nerve root compression at these levels consistent with claimant's subjective complaints. The claimant does have evidence of radiculopathy on physical examination; however, this has been stable and

remains unchanged during course of therapy. He previously has undergone physical therapy and epidural steroid injections without improvement. There is clear correlation between claimant's previous MRI and subjective complaints. There is no indication from available record that the claimant has progressive neurologic deficit that would warrant repeat imaging study. As such, the request falls outside ODG Guidelines and would not be 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)