

SENT VIA EMAIL OR FAX ON
May/21/2012

IRO Express Inc.

An Independent Review Organization

2131 N. Collins, #433409

Arlington, TX 76011

Phone: (817) 349-6420

Fax: (817) 549-0310

Email: resolutions.manager@iroexpress.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/21/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient CT/Myelogram of lumbar spine

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

Orthopedic 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

OD Guidelines

Notice of utilization review findings 03/27/12

Notice of utilization review findings 04/18/12

Summary letter to IRO 05/01/12

Neurosurgical consultation report 08/08/11

Progress notes 09/08/11-03/13/12

X-rays lumbar spine 01/11/11, 11/30/10 and 10/26/10

Operative report lumbar decompression and fusion L4-5 10/11/10

Notice of disputed issues and refusal to pay benefits 06/16/10

MRI lumbar spine 04/30/10

Neurophysiological monitoring report 10/11/10

Functional abilities evaluation 06/03/11

Physical performance evaluation 09/23/11

Treatment records 04/26/10 and 05/25/10

Progress notes 06/04/10-02/24/11

Procedure reports lumbar epidural steroid injections 06/21/10 and 07/30/10

Physical therapy progress notes 06/30/10-08/17/10

Procedure notes cervical epidural steroid injection 07/20/10

Notice of disputed issues and refusal to pay benefits 08/20/10

Office notes 03/09/11-01/18/12

Initial behavioral medicine consultation 03/21/11

Initial rehab therapy evaluation 03/17/11

Reevaluation and rehabilitation progress notes 05/10/11-01/26/12

Individual psychotherapy notes 06/03/11-07/12/11
Operative report lumbar transforaminal epidural steroid injection 11/22/11
Follow-up notes 02/18/12-04/11/12
Designated doctor evaluation 01/26/11
Report of maximum medical improvement/impairment 06/22/11 and 11/29/11
Designated doctor evaluation 06/28/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a whose date of injury is xx/xx/xx. Records indicate she was standing on a chair with casters when it slipped out from under her causing her to fall onto her buttocks and injuring her back. After undergoing a course of conservative care, the claimant was taken to surgery on 10/11/10 for bilateral L4-5 hemilaminotomy and foraminotomy with decompression of the L4 and L5 nerve roots, with transforaminal lumbar interbody fusion and posterior facet fusion L4-5. Following surgery the claimant participated in post-operative physical therapy. She also underwent epidural steroid injections. The claimant was seen in consultation by on 08/08/11. She was noted to be status post previous lumbar transforaminal interbody fusion at L4-5 performed in 10/10. She describes no improvement in her symptomatology post-operatively, and now describes pain level as 9/10 on VAS with worsening symptomatology after prolonged sitting, standing, coughing, sneezing or Valsalva maneuver. The claimant is status post physical therapy with no significant improvement. She denies bowel or bladder dysfunctions. X-rays of the lumbar spine performed 01/11/11 revealed post-operative changes with no hardware failure or loosening identified. There were no significant changes since prior study of 11/30/10. A CT myelogram of the lumbar spine was recommended to better evaluate previous lumbar fusion at L4-5. The claimant was seen by on 03/13/12 with chief complaint of back pain. Examination at that time revealed the claimant to be 5'4" tall and 285 pounds. Examination of the lumbar spine revealed moderate spasm and tenderness predominately in the right sacroiliac joint region. Forward flexion was only 30 degrees. Straight leg raise was positive on the right. Coordination was intact. Deep tendon reflexes were 1+ and symmetrical in the upper and lower extremities. Babinski reflex was normal bilaterally. Gait was steady. Sensation was slightly decreased to lower extremities to vibration. There was negative Spurling's, straight leg raise, clonus and Hoffman bilaterally.

A pre-authorization request for outpatient CT myelogram of the lumbar spine was reviewed on 03/27/12 and non-authorization was recommended. It was noted that on 03/21/12 the claimant was noted to have an interbody fusion and pain has worsened. Lumbar range of motion is decreased. Motor exam is 5/5. There was no progressive focal neurologic sign described. There was constant aching pain. There was an injection 11/21/11 with 60% pain reduction. MRI from 04/10 showed degenerative disease. There was an L4-5 transforaminal lumbar interbody fusion authorized in 2010. It was noted the records and evidence based citations do not support authorization of the request. There was no progression of neurologic deficit. Last MRI showed degenerative changes and no clear operable lesion.

A reconsideration request for outpatient CT myelogram of the lumbar spine was reviewed on 04/18/12, and the original decision was upheld and non-authorization again recommended. The reviewer noted there was limited information on the claimant's symptomatology. The notes only indicate the claimant has back pain and bilateral leg pain and pain that goes into the right thigh. None of the descriptions were consistent with a true radicular distribution of the pain, aggravating factors with no comprehensive evaluation of the claimant's symptoms. There was indication that the claimant also has depression and anxiety but no psychological evaluation of those secondary symptoms. Physical and neurological examinations were very limited and uncover only vague findings of leg weakness but no actual objective examination confirming the possibility of any weakness as well as some possible sensory changes. It was noted diagnosis is listed as low back pain; this is a symptom and not a diagnosis. The documentation does not confirm radiculitis. The claimant had a fusion in 10/11(2010?) but no report was submitted with the documentation.

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 CT myelogram of the

lumbar spine is indicated as medically necessary. The claimant was noted to have sustained an injury when she fell from a chair on xx/xx/xx. She was status post L4-5 decompression and fusion performed 10/11/10. Records indicate the claimant describes no improvement post-operatively in her symptoms. The claimant was treated with medications, physical therapy, and epidural injections with some improvement, but no resolution of symptoms. Plain radiographs of the lumbar spine revealed post-operative changes with posterior lumbar interbody fusion between L4 and L5; no hardware failure or loosening identified. According to an appeal letter from dated 05/01/12, since the claimant has mainly axial back pain with non-dermatomal leg pain and no other neurological findings he is concerned the claimant may have compromised her previous fusion in some way. In an effort to uncover issues with previous fusion and for surgical planning purposes notes it is prudent to order CT myelogram of the lumbar spine to better evaluate the previous lumbar fusion at L4-5. Per ODG guidelines, CT myelogram is indicated if MRI is unavailable, contraindicated or inconclusive; and for surgical planning. Noting that the claimant is status post lumbar fusion with retained hardware, MRI is contraindicated. Consequently, the proposed CT myelogram of the lumbar spine is supported as medically necessary to further assess current lumbar pathology and for surgical planning.

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)