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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Mar/12/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient lumbar myelogram CT with contrast

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

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year old female who has a date of injury of xxxxxx. On the date of injury, the claimant is reported to have slipped and fallen from a chair, sustaining an injury to her low back. Prior to this, the claimant had undergone a left discectomy and fusion at L4-5 with instrumentation on 11/25/97. Postoperatively, she was reported to have developed a discitis which required incision and drainage which was performed in 01/98. She was treated with antibiotics and had a history of persistent pain. She is noted to have improved until her workplace event of 02/09/09. The claimant failed to improve and she was subsequently returned to surgery on 12/03/09 which resulted in a decompression and exploration of the L5-S1 area. Records indicate that the claimant had continued complaints of pain postoperatively, despite exhaustive rehabilitative efforts. She was subsequently diagnosed with failed back surgery syndrome. She underwent EMG/NCV on 04/28/10 which notes evidence of a chronic, inactive left L5 radiculopathy. A repeat lumbar myelogram was performed on this date. This study notes posterior fusion of L4 and L5, unchanged. There is blunting of the left L4 nerve root. Amputation of the left L5 and S1 nerve roots is noted. These findings are not significantly changed when compared to a prior study dated 09/16/09.

There is a mild extradural bulge indenting the ventral aspect of the thecal sac at L3-4 which is unchanged. The claimant was subsequently recommended to undergo a trial of spinal cord stimulation which was initiated on 09/16/10. Records indicate that the claimant underwent permanent implantation on 11/10/10. Records indicate that the claimant initially had some benefit from dorsal column stimulation; however, over time, she has had diminished response. On 01/21/13, the claimant was seen by, FNP. She is reported to have low back pain radiating into her bilateral lower extremities. She reports having a 4-year history of back pain and no recent treatment. It is noted that the claimant has an implanted spinal cord stimulator but has not used it in the last 6 months because it was not covering her pain. She is reported to have had a readjustment over a year ago without relief of her symptoms. She uses a wheelchair most of the time due to pain as well as a walker, intermittently. On physical examination, she is noted to have difficulty acquiring a full upright position when getting out of the chair. She is noted to be 5'4" tall and 211 lbs. She has well-healed surgical scars. Her paravertebral muscles are tender bilaterally with spasms bilaterally. There are subjective reports of lower extremity weakness. Radiographs performed at this visit are reported to show disc height loss at L5-S1 with a stable fusion at L4-5 and a stable spinal cord stimulator implant. The claimant was recommended to receive additional diagnostics which include a CT myelogram of the lumbar spine.

The initial review was performed by Dr. on 01/25/13. Dr. non-certifies the request noting that there is no red flag condition or progression of neurologic deficit described in the clinical supplied. Furthermore, no possible surgery or injection is mentioned. He subsequently non-certifies the request.

The appeal request was reviewed by Dr. on 02/12/13. Dr. non-certifies the request noting that there is no red flag condition or progression of neurologic deficit described in the clinical supplied. Furthermore, no possible surgery or injection is mentioned.

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

The submitted clinical records indicate that the claimant is a xx year old female who has a pre-injury history of a spinal fusion and was injured on xxxx. On this date, the claimant slipped and fell from her chair, landing on her buttocks and aggravating her pre-existing conditions. Records indicate that the claimant underwent additional surgical intervention at the L5-S1 level. Postoperatively, the claimant is noted to have developed failed back surgery syndrome. The claimant's historical findings had been stable. There is no indication of progressive neurologic deficit which would establish the need for the performance of a CT myelogram. Therefore, in the absence of clear, supporting data which would establish the presence of a progressive neurologic deficit, it is this reviewer's opinion that medical necessity has not been established and the prior utilization review determinations are upheld.

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)