



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

Date: April 5, 2013

DATE OF REVIEW: 4/3/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar CT Myelogram

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

Texas State Licensed MD Board Certified Orthopedic Surgeon & Spine Surgeon

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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Texas Dept of Insurance Assignment to Medwork 3/18/2013,
2. Notice of assignment to URA 3/14/2013,
3. Confirmation of Receipt of a Request for a Review by an IRO 3/18/2013
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 3/15/2013
6. Letter office to IRO 3/18/2013, medical notes from attending physician 2/27/2013, notice of utilization review findings 2/13/2013, 2/4/2013, preauthorization form for outpatient visit 1/29/2013, medical notes (6 pages) 1/18/2013, medical notes from pain management facility 10/4/2012, medical notes 12/27/2012, 11/28/2012, 11/1/2012, 9/27/2012, 8/25/2012, 7/18/2012, 6/15/2012, 5/4/2012, medical notes from pain management 4/19/2012, medical notes 3/22/2012, 2/9/2012, 12/30/2011, 11/18/2011, 10/14/2011, 9/8/2011, 8/1/2011, 7/28/2011, 6/17/2011, follow up visit notes for general consultation 6/7/2011, medical notes 5/19/2011, 5/3/2011, 4/15/2011, 3/8/2011, follow-up case notes from general consultation 3/24/2011, medical notes 1/27/2011, 12/22/2010, 11/23/2010, 10/21/2010, 9/22/2010, 8/6/2010, 7/6/2010, 5/12/2010, 4/26/2010, review of medical notes from reviewing physician 4/26/2010, medical notes



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4/8/2010, medical notes 1/21/2010, medical notes 12/1/2009, review of medical notes from reviewing physician 11/16/2009, medical notes 9/17/2009, report from neurology center 8/19/2004, radiology report 7/29/2004, radiology report 12/11/2003, 10/28/2003, letter from orthopedic specialists 3/14/2003, radiology report 6/8/2001, doctor evaluation for workers compensation 3/1/2001, report of medical evaluation 2/22/2001, designated doctor examination 2/20/2001, follow-up report from orthopedic rehabilitation 11/27/2000, medical notes from CT scan 9/19/2000, images (6 pages), employer's first report of injury 10/27/1998.

PATIENT CLINICAL HISTORY:

The patient was well documented to be an individual with a history of a so called failed back syndrome. The patient has been most recently treated with a spinal cord stimulator. The patient is noted to be status post fusion with persistent back pain and radiculopathy. The patient has been noted to be on high doses of narcotic analgesics. The CT scan of the lumbar spine dated 12/11/2003 was noted to reveal that the patient is indeed post bony fusion between L5 and S1, and has diffuse degenerative facet disease at all levels, especially the lower 3, and has approximately a 4 mm posterolateral disk herniation with impingement on the left neural foraminal exit at L4 to L5. That was as of 12/12/2003. The patient was also documented to have evidence of a recent pain management evaluation. That evaluation was dated 01/18/2013. Within the evaluation itself, the original history of having been injured while performing heavy lifting was well documented. The patient has been most recently documented to have bilateral positive straight leg raise, and restricted lumbar range of motion, along with a grossly within normal limits motor exam. The sensory exam, however, revealed "sharp pain from the low back down bilateral lower extremities at dermatomes L5-S1." The impression as noted has been that of failed back surgery syndrome with chronic pain syndrome and low back pain with radicular symptoms. The patient was felt to have an indication for a lumbar CT myelogram at that time, and the rationale for the test was due to the aforementioned subjective and objective findings overall.

The records next revealed on 02/27/2013 that the patient was felt to have "metal in her body and is unable to complete an MRI. The patient would benefit from CT myelogram of the lumbar spine due to the magnetic effect of her bone stimulator." The patient was felt to have completed treatment "without relief for the past 17 years.... has had back surgery without improvement. I believe the patient should have psychological clearance for a trial spinal cord stimulator."

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

The patient has had a thorough diagnostic and therapeutic intervention throughout the years. She continues unfortunately to have a diagnosis well established as that of failed back surgery syndrome. The documentation does not evidence that there has been positive red flags evidencing a progressive or severe neurologic deficit. The applicable clinical guidelines would only support essentially a repeat imaging study, in this case, certainly the CT scan, when there has been such progressive neurologic pathology and/or severe pathology and/or surgical



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intervention is being planned. At this point, with the spinal stimulator already in place and without any more aggressive form of planned surgical intervention, and with the recent CT scan having been already performed with it being essentially a diagnostic test in itself, at this point a CT/myelogram is not reasonable or medically necessary as per applicable clinical guidelines including ODG. There is no indication for a CT myelogram at this time based on the thoroughness of the prior diagnostics, their results/outcomes, and the lack of any evidence of significant progression or red flags since the most recent diagnostics.

The denial of these services is upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)