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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Apr/19/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Myelogram with Post Myelogram CT Scan

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

Neurosurgery

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:

ODG - Official Disability Guidelines & Treatment Guidelines
CT scan lumbar spine 02/04/13
CT scan thoracic spine 02/04/13
Clinical notes 02/25/13 and 03/12/13
Previous utilization reviews 03/07/13 and 03/20/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury to his low back. CT scan of the lumbar spine dated 02/04/13 revealed spondylosis at T12-L1 with advanced degenerative disc disease. A diffuse disc bulge mildly flattening the ventral margin of the thecal sac was noted. A prior discectomy and fusion were noted at L2-3. Prior laminectomy was further noted at L3-4 with a bony fusion. No stenosis was noted at the L2-3 or L3-4 levels. A discectomy and fusion were also noted at L4-5 with a prior laminectomy. Prior discectomy and fusion were also noted at L5-S1. Clinical note dated 02/25/13 detailed the patient previously undergoing spinal cord stimulator implantation. The patient noted an increase in low back pain as well as bilateral lower extremity pain with associated burning and tingling. Upon exam, the patient ambulated with an antalgic gait. The patient demonstrated 10 degrees of lumbar flexion. 4/5 strength was noted with plantar flexion. Clinical note dated 03/12/13 detailed the patient complaining of weakness in the bilateral lower extremities specifically in the S1 distribution. The note further detailed the specific request for a myelogram in order to rule out nerve root compression that the previous CT scans did not reveal.

The previous utilization review dated 03/07/13 resulted in a denial secondary to a lack of information regarding the need for additional diagnostic information. Furthermore, no information was submitted regarding surgical intervention at that time.

The previous utilization review dated 03/20/13 also resulted in a denial secondary to a lack of information indicating the need for further diagnostic studies as well as a lack of information regarding the need for surgical intervention.

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

The documentation submitted for review elaborates the patient complaining of ongoing low back pain despite a previous surgical intervention. The Official Disability Guidelines recommend a CT myelogram in the lumbar spine provided that the patient meets specific criteria including the need for surgical planning or physical findings which do not correlate with imaging studies. No information was submitted regarding the poor correlation with previous imaging studies. Additionally, it is unclear if the patient is planning for surgical intervention in the lumbar spine. As no information was submitted regarding the need for surgical intervention and taking into account the lack of information regarding the poor correlation of physical findings in relation to the previous imaging studies, this request is not indicated. As such, it is the opinion of this reviewer that the request for a post-myelogram CT scan is not recommended as medically necessary and the prior denials 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)