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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Feb/13/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Lumbar myelogram with CT

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D. O. Board Certified Neurological Surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] 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. It is the opinion of this reviewer that medical necessity for Lumbar myelogram with CT is not established.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 01/11/13
Reconsideration/appeal of adverse determination dated 01/25/13
Office notes dated 12/20/10 – 01/28/13
Operative report dated 03/28/12
Discharge summary dated 03/30/12
History and physical 03/28/12
CT myelogram lumbar spine dated 02/18/11
CT myelogram cervical spine dated 05/10/11
X-rays lumbar spine with F/E views dated 07/29/11
Procedure report epidural steroid injection left L4-5 dated 01/15/11

PATIENT CLINICAL HISTORY [SUMMARY]: The claimant is a male whose date of injury is xx/xx/xx. Records indicate that he fell through a floor and experienced an onset of posterior cervical, lumbar, bilateral hip, bilateral leg, and interscapular pain with bilateral shoulder and arm pain, particularly on the left. After failing a course of conservative care including physical therapy, medications, and epidural steroid injections, the claimant underwent L3-5 decompressive laminectomy on 03/30/12. Records indicate that the claimant had excellent relief of radiculopathy with no radiating hip or leg pain, but had residual mechanical pain in the lumbar spine. Because of persistent lumbar pain and aching pain in the hips and legs with some persistent neurologic deficits, the claimant was recommended to undergo a lumbar myelogram and CT scan.

A utilization review determination dated 01/11/13 determined the request for lumbar CT myelogram to be non-certified, noting that there were no significant physical examination

findings to support the medical necessity of a CT myelogram. The claimant was not noted to have any objective physical examination findings of lumbar radiculopathy, and there was no documentation of any hardware that would prevent the claimant from having a MRI study. Without findings of worsening or progressive neurologic dysfunction, treatment guidelines would not support additional or repeat imaging studies. It was noted that the requesting provider desires to proceed with lumbar spine fusion but x-ray studies from 01/08/12 document good alignment of the lumbar spine. Without segmental instability, treatment guidelines would not support a fusion procedure. If the CT myelogram is being proposed to evaluate the claimant for a future procedure, it is not within treatment guidelines.

A reconsideration/appeal of adverse determination dated 01/26/13 determined that a lumbar myelogram with CT was not certified. It was noted that the request previously was denied due to lack of documentation of objective evidence of radiculopathy. The claimant was noted to be undergoing medication therapy, lumbar decompression, and foraminotomies. The claimant had ongoing complaints of mechanical pain and unspecified neurological deficits. The Official Disability Guidelines recommend a CT with myelogram for suspected spinal leaks or for diagnostic evaluations of spinal disease. The information submitted does not document any suspicions of spinal leak or infection. The information submitted lacks any documentation of any change or contraindication of the claimant's status that would warrant a CT myelogram and the appeal request for lumbar myelogram and CT is non-certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The male sustained an injury on xx/xx/xx. After failing a course of conservative care, the claimant underwent a decompressive laminectomy at L3-5 performed on 03/28/12. Subsequent records indicate that the claimant continued with residual mechanical pain in the lumbar spine and aching pain in the hips and legs with some persistent neurologic deficit. The most recent note dated 01/28/13 indicates that the claimant walks with a cane; has diminished range of motion of the low back with paralumbar muscular tightness and loss of lumbar lordosis; positive straight leg raising bilaterally; weakness of the lower legs with some decreased sensation. However, the examination did not detail the motor weakness and decreased sensation to be in a specific myotomal or dermatomal distribution. There was also no indication of the severity of the motor sensory deficits. There was no indication that MRI of the lumbar spine was unavailable, contraindicated, or inconclusive. Based on the clinical data provided, it is the opinion of this reviewer that medical necessity for Lumbar myelogram with CT is not established.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)