

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/04/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: lumbar myelogram w/CT and IV protocol

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:M.D., Board Certified Orthopedic 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. It is the opinion of this reviewer that the requested lumbar myelogram w/CT and IV protocol is medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his low back. The MRI of the lumbar spine dated 12/04/13 revealed a broad based disc protrusion at L2-3. Mild ligamentum flavum and facet hypertrophy were identified causing moderate canal stenosis. Mild to moderate bilateral neuroforaminal narrowing was also revealed. Severe bilateral neuroforaminal narrowing was also identified at L4-5. Mild left and moderate right neuroforaminal narrowing was also revealed at L5-S1. The clinical note dated 01/21/14 indicates the patient complaining of low back pain along with weakness in the thighs. The patient stated that sitting for prolonged periods of time exacerbated his pain levels. The clinical note dated 03/18/14 indicates the patient complaining of low back issues. The patient was being recommended for a neurological evaluation at that time. The clinical note dated 04/22/14 indicates the patient being recommended for a lumbar myelogram. The note indicates the patient undergoing surgical planning.

The utilization review dated 04/02/14 resulted in a denial as no information had been submitted regarding an evaluation and significant findings of stenosis.

The utilization review dated 04/17/14 resulted in a denial as insufficient information had been submitted demonstrating any functional deficits.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient having complaints of ongoing low back pain. The use of a CT myelogram is indicated for patients who are in need of surgical planning. There is an indication the patient is being planned to undergo a surgery in the lumbar region to address the findings confirmed by the MRI regarding the L2-3 level as well as potential findings at the L5-S1 level indicating severe bilateral neuroforaminal narrowing. Given the need for surgical planning, this request is indicated. As such, it is the opinion of this reviewer that the requested lumbar myelogram

w/CT and IV protocol is medically necessary and the prior denials are overturned.

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)