Medwork Independent Review
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ACCREDITED INDEPENDENT REVIEW ORGANIZATION

MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 11/16/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
CT myelogram to lumbar spine.

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 11/14/2012,
2. Notice of assignment to URA 11/13/2012,
3. Confirmation of Receipt of a Request for a Review by an IRO 11/14/2012
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 11/14/2012
6. Letter to IRO from patient 11/14/2012, letter to patient from insurance company 10/23/2012, 10/17/2012, peer review report 10/17/2012, appeal request 10/1/2012, letter to patient from insurance company 9/27/2012, peer review report 9/24/2012, outpatient imaging requisition nod dated, medical documents 9/21/2012 letter to physician 6/6/2011.

PATIENT CLINICAL HISTORY:
The patient has been noted to be having been injured on xx/xx/xx while lifting. The patient has been documented throughout the attending physician's records from the treating provider, to have an indication for a CT myelogram. The patient is noted to have assessment of lumbar radiculopathy and lumbosacral spondylosis and postlaminectomy syndrome. The patient is status post multiple spinal surgical interventions including in 1999 and more recently in 2002 when he underwent a fusion of the L5-S1 level. He reports ongoing back pain with radiation into the right leg along with bilateral leg paresthesias and right leg weakness. Expressly when "he stands, walks or lifts". The CT scan of the lumbar spine referenced in the progress note of 09/21/2012 and in itself was dated 06/06/2011 there was evidence of postoperative changes and mild disk

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bulges at multiple levels of the lumbosacral spine. The patient despite treatments with medications and therapy and ESIs, has only had mild improvement documented. The most recent attending physician's records document that the patient's neurologic findings with regards to sensation, motor, power, and reflexes in the lower extremities is noted to be unremarkable.

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

With no documented evidence that the patient has any significant new neurologic symptoms and without evidence of any abnormal neurologic findings on clinical examination, i.e. the lack of objective evidence of radiculopathy, there is no indication for a CT myelogram at this time. This is especially valid that due to the fact that the patient had a fire postoperative CT scan from a year ago in which there were no significant abnormal findings either. Therefore, without any documentation of any new symptoms, significant or severe or acute objective findings, and/or imaging findings supportive of an indication for a CT myelogram, applicable ODG criteria for CT scan and myelogram has not been met at this time.
The denial of 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)**