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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: 07/19/07

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Items in Dispute: Lumbar myelography with CT.

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

Texas License and currently on TDI DWC ADL.
Board Certified Neurosurgeon

REVIEW OUTCOME:

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. Medical records Dr. dated 01/15/03 – 05/29/07.
2. Report of CT myelogram dated 01/15/03.
3. Post myelogram CT dated 01/15/03.
4. Operative report dated 02/05/03.
5. Operative report dated 01/09/04.
6. MRI of the lumbar spine dated 03/04/04.
7. Report of myelography dated 10/05/04.
8. Procedure report dated 03/31/06.
9. Report of lumbar myelography dated 04/28/06.

INJURED EMPLOYEE CLINICAL HISTORY (SUMMARY):

The employee is a male who is currently under the care of Dr.

The reviewable record begins on 01/15/03. At that time, the employee was reported to have back and leg pain. The employee underwent lumbar myelography on that date. Dr. notes indicated that a central defect was found at L3-L4 with a slight retrolisthesis of L3 on L4, and there was some narrowing at the L5-S1 interspace. There was no definite lateralizing defect.

The employee was subsequently referred for CT. This study reported a normal appearing canal with normal alignment with mild disc space narrowing at L5-S1 and a slight retrolisthesis of L5 on S1. There was a small soft tissue bulge at L4-L5 and L5-S1 with no significant impingement upon the canal. Axial images revealed a mild broad-based disc bulge at L3-L4 with no spinal and no foraminal stenosis. L4-L5 and L5-S1 were unremarkable.

The employee was subsequently taken to surgery on 02/05/03, and at that time, the employee underwent L3-L5 decompressive laminectomies, decompression of the nerve roots, anterior spinal column arthrodesis using interbody cages with pedicle screws and rods, and a posterolateral fusion. Postoperatively the employee was reported to no longer have any hip or leg pain. He was noted to be ambulatory in the hall with a brace.

Postoperatively, the employee appeared to make an excellent recovery and was noted to have progressive posterolateral and interbody fusion at nine months. He had no radiating hip or leg pain. However, he was provided a lumbar epidural steroid injection, which was reported to have given him some benefit. It was further reported that the employee was quite depressed and approximately a month earlier had shot himself in the right chest with a gun.

On 01/09/04, the employee underwent a removal of a right paralumbar subcutaneous spinal fusion stimulator and battery.

On 02/16/04, it was reported that the employee was one month status post removal of a subcutaneous spinal fusion stimulator battery in the lumbar area. His incision was well-healed. The employee was reported to have some discomfort in the left lumbosacral area with some discomfort down the left leg.

On 03/08/04, Dr. reported that the employee had previously undergone a lumbar MRI scan on 03/04/04, which revealed some mild postoperative changes with no evidence of scarring, herniated disc, root compression, or stenosis.

Because of the employee's continued pain and dysfunction, a second lumbar myelogram was performed on 10/05/04. At that time, it was reported that there was minimal central and bilateral L2-L3 defects. Additional medical records indicated that in the interval period, the employee had no major exacerbations and reported a fairly consistent aching pain.

A serial note dated 03/20/06 indicated the employee has no neurologic deficits, and it was felt that the employee would be a good candidate for a lumbar epidural steroid injection. It was also suggested that the employee have a lumbar myelogram.

The employee underwent a third myelogram on 04/28/06. This study again reported a central defect at L2-L3.

Additional records indicate that Dr. has recommended that the employee undergo another lumbar myelogram secondary to continued low back pain.

Citation:
ODG

CT & CT Myelography (computed tomography)	Not recommended except for indications below for CT. CT Myelography OK if MRI unavailable, contraindicated (e.g. metallic foreign body), or inconclusive. (Slebus, 1988) (Bigos, 1999) (ACR, 2000) (Airaksinen, 2006) Magnetic resonance imaging has largely replaced computed tomography scanning in the noninvasive evaluation of patients with painful myelopathy because of superior soft tissue resolution and multiplanar capability. Invasive evaluation by means of myelography and computed tomography myelography may be supplemental when visualization of neural structures is required for surgical planning or other specific problem solving. (Seidenwurm, 2000) Indications for imaging -- Computed tomography: <ul style="list-style-type: none">- Thoracic spine trauma: equivocal or positive plain films, no neurological deficit- Thoracic spine trauma: with neurological deficit- Lumbar spine trauma: trauma, neurological deficit- Lumbar spine trauma: seat belt (chance) fracture- Myelopathy (neurological deficit related to the spinal cord), traumatic- Myelopathy, infectious disease patient
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ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The request for lumbar myelography is not supported by the submitted medical documentation. The available medical records indicate that the employee is status post multilevel fusion and has chronic low back pain with no evidence of a progressive neurologic deficit which would warrant CT/myelography.

If the IMED's decision is contrary to: (1) the DWC's policies or guidelines adopted under Labor Code §413.011, IMED must indicate in the decision the specific basis for its divergence in the review of medical necessity of non-network health care or (2) the networks treatment guidelines, IMED must indicate in the decision the specific basis for its divergence in the review of medical necessity of network health care.

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

1. The *Official Disability Guidelines*, 11th edition, The Work Loss Data Institute.
2. The *American College of Occupational and Environmental Medicine Guidelines*. Chapter 12.