



# Lumetra

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## IRO NOTICE OF DECISION – WC

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**DATE OF REVIEW:** 07-08-2007

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Electromyogram / Nerve Conduction Study (EMG/NCS), Bilateral Lower Extremities and Lumbar Myelogram CT

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

Certified by the American Board of Neurological Surgery  
General Certificate in Neurological Surgery  
Spine-Fellowship Trained Neurological 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)

Injury Date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Service Units	Upheld/ Overturn
		Prospective	724.02	95861 95904 72265 72131	1	Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Notice of Findings (06-21-2007 and 06-25-2007)

Medical Evaluation (06-06-2007)  
Physician Progress Notes (10-19-2006, 12-07-2006, 06-14-2007)  
History and Physical Examination Note (08-08-2006)  
Preoperative History and Physical (10-02-2006)  
Operative Report (10-02-2006)  
Discharge Summary (Service date: 10-02-2006 to 10-06-2006)  
Three Views Cervical Spine (07-28-01)  
Chest 2V (09-07-2006)  
MRI L-Spine W/O Contrast (01-18-06)  
L-Spine 2V-3V  
Lumbar Spine X-Ray (12-06-2006)  
Five-view Lumbar region Spine X-rays (06-13-2007)  
Texas Workers' Compensation Status Report

### **PATIENT CLINICAL HISTORY:**

The claimant suffered a work related fall type injury to his right knee and low back. The knee improved with non-surgical treatments. However, continued low back symptoms lead to a lumbar MRI revealing severe spinal stenosis at L3-4 and L4-5 (given that there is transitional anatomy). The claimant was treated with physical therapy, epidural injections, and finally, decompressive surgery with instrumental fusion L4-L5. Despite some improvement with pain, additional testing is requested as noted, above.

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

After review of the records submitted, there are two separate requests, with only the EMG/NCV being requested to access for "acute" changes. The CT-myelogram was requested to search for arachnoiditis. The Reviewer separated these requests for clarity.

1. EMG/NCV low back and lower extremities. A request being made on the basis of acute changes when the physician's report of June 14, 2007 discusses the "chronicity" of symptoms. The treating physician is trying to rule out "arachnoiditis". The electrodiagnostic test is requested to see if there is an "acute process". However, the progress notes of June 14 do not provide a basis for any acute subjective or physical examination findings to substantiate the request. Further, the claimant's use of medication is not detailed this visit, as it had been in previous notes. The review of x-rays shows good position of the grafts and fusion. There is no evidence in either physician's reports for acute lower extremity radiculopathy. A request to obtain a postoperative lumbar and lower extremity electrodiagnostic test, while not unreasonable in the face of continued (despite improved) symptoms, is not supported by the ODG Guidelines. Pre-operative imaging has already supported the location of the lumbar problems related to this industrial claim. There is no documentation of alternative radicular involvement to support the approval of a post-operative electrodiagnostic study.

Opinions to the contrary may be considered for post-operative imaging that show new levels of neural compression, or multiple levels of persistent compressions causing a diagnostic confusion towards considering further intervention. The basis has not been provided to date. It is the opinion of the Reviewer to uphold the denial for electrodiagnostic testing at this time as described above.

2. Request for CT Myelogram. The diagnosis of arachnoiditis is nebulous. Even if a CT-myelogram found evidence for arachnoiditis, it appears that the claimant largely controls his pain with medications (i.e. the treatment plan would not likely change). This is supported in the physician's report of June 6, 2007 as well as the treating physician's opinion that chronic pain management treatment would be necessary.

Although post-operative imaging is not unreasonable, it does not appear that the more affordable and less invasive post-operative MRI has been obtained (with or without contrast) first. The MRI would be more than adequate to provide that diagnosis of arachnoiditis or other post-operative issues, if they exist. CT-myelogram should be reserved for difficult to interpret MRIs, and for patients that cannot have MRIs for various reasons.

The Reviewer is of the opinion to uphold the denial of the request for CT-myelogram as described. Options may be considered to re-evaluate the patient in terms of the trend of his improvement based on medication use and further pain management options and consider additional imaging for reasons for which an appropriate treatment plan would benefit. This decision is consistent with ODG Guidelines.

**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)