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**DATE OF REVIEW:** 05/22/07

**IRO CASE #:**

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

Lumbar myelogram with post myelographic CT

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

Board certified Orthopaedic Surgeon, licensed in the State of Texas, and DWC ADL Approved.

**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)

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Lumbar myelogram with post myelographic CT			Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Record Description	Record Date	Pages
1. Diagnostic Test –Center	xx/xx/xx	2
2. Diagnostic Test –	12/02/06	1
3. Office Visit Report – Dr.	12/26/06	1
4. Office Visit Report – Dr.	04/02/07	1
5. Diagnostic Test –Imaging	04/03/07	3
6. Initial preauthorization denial letter –	04/05/07	2
7. Appeal of preauthorization denial –	04/26/07	2

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

Claimant was injured on xx/xx/xx. Medical information was reviewed, specifically Dr. clinic notes dated 12/6/06 and 4/2/07. The patient is status post L4-S1 fusion and presents to Dr. once again in the last 4-5 months with continued back pain, buttocks pain and lower extremity foot pain. The most complete note authored by Dr. is in handwritten format date 4/2/07 documenting the symptoms noted.

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

However, there is a failure of any documentation of physical examination findings to suggest the invasive diagnostic testing is warranted. Diagnostic imaging in and of itself can lead to erroneous conclusions and needs clinical correlation as a basis and foundation to order the appropriate testing. Based on the information provided, the services are inconsistent with evidence based medicine as quoted above.

The current online version of ODG references when imaging of the spine is indicated. Recommended for indications below:

MRI's are test of choice for patients with prior back surgery. Repeat MRI's are indicated only if there has been progression of neurologic deficit. (Bigos, 1999) (Mullin, 2000) (ACR, 2000) (AAN, 1994) (2004) (Airaksinen, 2006) Magnetic resonance imaging has also become the mainstay in the evaluation of myelopathy. An important limitation of magnetic resonance imaging in the diagnosis of myelopathy is its high sensitivity. The ease with which the study depicts expansion and compression of the spinal cord in the myelopathic patient may lead to false positive examinations and inappropriately aggressive therapy if findings are interpreted incorrectly. (Seidenwurm, 2000) There is controversy over whether they result in higher costs compared to X-rays including all the treatment that continues after the more sensitive MRI reveals the usual insignificant disc bulges and herniations. (Jarvik-JAMA, 2003) In addition, the sensitivities of the only significant MRI parameters, disc height narrowing and annular tears, are poor, and these findings alone are of limited clinical importance. (Videman, 2003) Imaging studies are used most practically as confirmation studies once a working diagnosis is determined. MRI, although excellent at defining tumor, infection, and nerve compression, can be too sensitive with regard to degenerative disease findings and commonly displays pathology that is not responsible for the patient's symptoms. With low back pain, clinical judgment begins and ends with an understanding of a patient's life and circumstances as much as with their specific spinal pathology. (Carragee, 2004). Indications for imaging -- Magnetic resonance imaging: - Thoracic spine trauma: with neurological deficit - Lumbar spine trauma: trauma, neurological deficit - Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit) - Uncomplicated low back pain, suspicion of cancer, infection - Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. (For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.) (Andersson, 2000) - Uncomplicated low back pain, prior lumbar surgery - Uncomplicated low back pain, cauda equina syndrome - Myelopathy (neurological deficit related to the spinal cord), traumatic myelopathy, painful, - Myelopathy, sudden onset - Myelopathy, stepwise progressive - Myelopathy, slowly progressive - Myelopathy, infectious disease patient - Myelopathy

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

The current online version of ODG references when imaging of the spine is indicated: (Bigos, 1999), (Mullin, 2000), (ACR, 2000), (AAN, 1994), (2004), (Airaksinen, 2006), (Seidenwurm, 2000), (Jarvik-JAMA, 2003), (Videman, 2003), (Carragee, 2004), (For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.), (Andersson, 2000).