

# IRO Express Inc.

An Independent Review Organization

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## IRO REVIEWER REPORT TEMPLATE -WC

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**DATE OF REVIEW:** OCTOBER 15, 2007

**IRO CASE #:**

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

Lumbar myelogram with CT scan

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

Board Certified Orthopedic 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

MRI lumbar spine, 06/19/03

CT lumbar spine, 07/30/03

Discogram, 09/03/03

Office notes, 11/03/03, 02/25/04

Lumbosacral spine AP and lateral, 11/09/03

CT lumbar spine unenhanced, 02/19/04

Lumbar myelogram, 02/19/04

Lumbar myelogram followed by CT, 02/19/04

MRI thoracic spine, 03/16/04

Office notes, 04/14/04, 11/21/06, 02/20/07, 04/20/07, 06/26/07

MRI lumbar spine without enhancement, 08/20/04

Office note, 01/20/06

HEALTH AND WC NETWORK CERTIFICATION & QA 10/31/2007

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Office note, 08/18/06  
peer review, 07/31/07  
Letter to, 08/15/07  
Peer review, 08/22/07  
Letter from attorney, 10/01/07  
No ODG Guidelines

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

This is a male construction worker who was status post four lumbar surgeries with the most recent one being a xx/xx/xx for decompression at L3-4 and L4-5. At the time of the surgery, it was noted that the claimant's L5-S1 fusion was solid. The 08/20/04 MRI of the lumbar spine showed post surgical changes at L5-S1, slight deformity of the superior endplate of L5 and there was possibly an old compression deformity of this area but findings appeared to be long standing.

Dr. performed an independent medical examination on 01/20/06 and recommended a urology consult to determine if the claimant had a neurogenic bladder, medication, antidepressants and consideration for spinal cord stimulator or morphine pump. Dr. of pain management on 08/18/06 diagnosed the claimant with failed back syndrome, lumbar discogenic pain, lumbar radiculopathy, bilateral facet syndrome, bilateral sacroiliitis and myofascial pain syndrome. Dr. recommended a chronic pain management program and medication.

The claimant saw Dr. on 02/20/07 for complaints of severe back and leg pain. Dr. noted the results of the 2002 and 2004 electromyography which showed progression of his radiculopathy with acute changes at L3 through S1 distribution. Dr. noted that Dr. noticed some findings consistent with some worsening consistent of his clinical bowel and bladder incontinence and that it was perplexing that the claimant had a normal myelogram and CT scan yet had significant radicular components clinically by electrodiagnostics involving the L3 nerve roots. Examination showed positive straight leg raise at 60 degrees on the right and 50 degrees on the left. Ankle jerks were diminished but present. Electromyography and MS were recommended. On 04/20/07, Dr. noted that the 03/26/07 electromyography showed irritability bilaterally at L4, L5 and S1 motor nerve roots with greater power reduction on the left side but without any active denervation and that Dr. had stated that there was improvement in the bilateral L3 motor nerve roots which were involved in the 2004 study. Dr. also noted that Dr. felt there was less overall reduction in external and sphincter pattern. Dr. noted that the MRI previously demonstrated arachnoiditis which was a radiological diagnosis without any histological confirmation. Dr. recommended a gastrointestinal and urology consult; however, this recommendation was denied by the insurance carrier. The claimant was seen by Dr. on 06/26/07 and documented that the claimant had various and sundry complaints that were difficult to explain. The claimant had reported an increase in pain over the last 3 to 4 weeks. Examination revealed strength of  $\frac{3}{4}$  in the extensor hallucis longus and absent right ankle reflex. X-rays that day showed intact interbody fusion and wide neural foramen at L3-4, L4-5 and L5-S1 bilaterally. Dr. recommended off work and lumbar CT myelogram to see if there is any possibility that there is lumbar pathology.

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

This claimant's findings are somewhat worrisome in that electrodiagnostic tests of 2002, 2004 and 2007 reveal ongoing changes at multiple nerve roots. An MRI has demonstrated arachnoiditis. Physical findings include ongoing weakness at the extensor hallucis longus muscle and diminished reflexes.

On the basis of all information available, the Reviewer would recommend that the lumbar myelogram with CT scan be considered medically necessary in this case.

While the ODG guidelines outline that magnetic resonance imaging has largely replaced CT scanning for the evaluation of the lumbar spine, there are some very important considerations in this claimant's case. Clearly, arachnoiditis has been a consideration. The instillation of a contrast medium would help truly see whether or not there are nerve roots compressed by scar, recurrent disc, or any other source. In difficult postoperative cases, the lumbar CT scan with myelogram remains the gold standard. Particularly in the consideration of arachnoiditis from the prior MRI, the Reviewer would consider the CT myelogram to be a better test for this specific patient. Ongoing electrodiagnostic changes and ongoing neurologic findings on physical examination also render this claimant a reasonable candidate for CT myelography.

Official Disability Guidelines Treatment in Workers' Comp 2007 Updates, Low back, CT myelogram

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:**

- 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

**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)