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DATE OF REVIEW: OCTOBER 8, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Myelogram with CT and Reconstruction.

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

This case was reviewed by a licensed MD, specializing in Orthopedic Surgery.

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 CT and reconstruction	72265, 72131, 76375	Upon Approval	Adverse Determination Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Description of medical records	Date
Report of medical evaluation to referring physician Dr.– MD	04/22/04
Operative Report – Micro-lumbar discectomy –MD	06/11/04
MRI of lumbar – Nydic –MD	06/10/06
Office Visit & Referral for Myelogram with CT of lumbar –MD	07/26/06
Utilization Review Request – CT & Lumbar Myelogram –Imaging	08/14/06
Utilization Review Request – Adverse determination for Lumbar Myelography with CT Scan and reconstruction – Injury Management (ODG Guideline listed as utilized – specifics not included)	08/18/06
Lower extremity EMG & Nerve Conduction Studies – Neuro EMG, PA –MD	08/24/06
Appeal letter regarding denial of CT Myelogram and EMG –MD	08/25/06
Utilization Review Appeal - CT & Lumbar Myelogram –Imaging & Diagnostic	08/29/06
Utilization Review Appeal – Adverse determination for Lumbar Myelography with CT Scan and reconstruction – Injury Management (ODG Guideline listed as utilized – specifics not included)	09/07/06

Office Visit –MD	07/25/07
Medical Conference Note with Dr.– MD	08/07/07
Utilization Review Request - Lumbar Myelography with CT Scan and reconstruction –MD	Unknown
Utilization Review Request – Adverse determination for Lumbar Myelography with CT Scan and reconstruction – Injury Management (ODG Guideline listed as utilized – specifics not included)	08/09/07
Appeal Letter regarding denial of lumbar myelogram –MD	08/16/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male. The most recent medical, dated 07/25/07, reports claimant has a pain level of 4-5/10 in the low back and right leg. He continues to work. He reports to have had these symptoms since Dr. did a laminectomy in 2004 for an L5-S1 herniation and right leg pain. Dr. noted 4+/5 right great toe dorsiflexion weakness and 0/5 great toe flexion weakness, an absent right reflex, decreased lumbar ROM, a positive straight leg raise on the right and hypesthesia over the right foot to touch and pin prick. Dr. however, on 07/26/06 noted 4-5 weakness of the dorsiflexors and plantar flexors of the right foot and a positive right straight leg raise.

The claimant had a lumbar contrast MRI on 06/10/06 which did not reveal a recurrent disc or stenosis or residual disc. An EMG dated 08/24/06 revealed bilateral L4 and L5 radiculopathies. The F-wave test was positive, but the H-reflex test was normal. Bilateral sensory evoked potential done on the same day were within normal limits.

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

This patient’s current complaints cannot be adequately evaluated with a CT/myelogram because scar tissue is demonstrated the same as disc tissue. This may lead to an unnecessary operation if the findings due to scar tissue are misinterpreted as recurrent disc tissue. Therefore, based upon the above rationale the request for a CT/myelogram is not approved.

The diagnostic study of choice to evaluate patients with back pain with prior back surgery is a contrast MRI (ODG, 4th ed, p.822, 2006). A contrast MRI normally differentiates recurrent disc tissue herniation from scar tissue from previous surgery. A CT/myelogram does not have this capability and is to be used only when MRI is not available (ODG, 4th ed, p 823, 2006). EMGs have about a 20% rate of false positives (J. Am. Acad. Of Ortho. Surgeons; 2004; 12:276).

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

ODG:

TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS: the Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with Rule 102.4(h), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on .