

# MATUTECH, INC.

PO Box 310069  
New Braunfels, TX 78131  
Phone: 800-929-9078  
Fax: 800-570-9544

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**Amended: April 29, 2008**

Notice of Independent Review Decision

AMENDED: April 29, 2008

**DATE OF REVIEW: APRIL 23, 2008**

**IRO CASE #:**

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

Thoracic myelography, radiological supervision and interpretation

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

The physician providing this review is a spinal neurosurgeon. The reviewer is national board certified in neurological surgery. The reviewer is a member of the American Association of Neurological Surgeons, The Congress of Neurological Surgeons, The Texas Medical Association, and The American Medical Association. The reviewer has been in active practice for 38 years.

**REVIEW OUTCOME**

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

Overturned (Disagree)

Medical documentation supports the medical necessity of Thoracic myelography, radiological supervision and interpretation.

ODG criteria have been used for denial.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a xx-year-old who was injured on xx/xx/xx. He was moving a 95-gallon drum out of a small containment. The drum turned over knocking him down in a twisting motion onto his right shoulder and injuring his mid and lower back.

The patient was initially treated with medications and therapy.

Magnetic resonance imaging (MRI) of the thoracic spine revealed minimum-to-

moderate degree of spondylosis throughout, and early disc desiccation in the mid thoracic spine with minimal bulging discs involving the T6-T7, T7-T8, and T8-T9 levels. MRI of the lumbar spine revealed minimum-to-moderate degree of spondylosis throughout; evidence of early spinal stenosis, foraminal stenosis, and broad-based bulging discs at L3-L4, L4-L5, and L5-S1. In xx/xx, a lumbar discography revealed extravasations of the contrast at L5-S1 with severe concordant pain.

On February 15, 2007, M.D., performed a 360-degree fusion at L5-S1 and total laminectomy at L5 and partial bilateral laminectomy at S1.

In January 2008, MRI of the thoracic spine was essentially unremarkable. Dr. noted the patient had been treated by epidural steroid injection (ESI) and trigger point injection (TPI) to the interspinous ligaments at T6-T7 and T7-T8, which had given 30% pain relief.

On March 6, 2008, M.D., a neurosurgeon, noted there was no improvement with the lumbar surgery. The patient was utilizing hydrocodone, Effexor, and Rozerem and was under chronic pain management. He continued to have bilateral radiating hip and leg pain, worse on the left. Examination showed decreased mobility of the lower back in all directions and tenderness over both sciatic outlets primarily on the left. There was some difficulty toe and heel standing on the left and scattered hypalgesia below the knees, particularly on the left. Dr. diagnosed severe chronic posttraumatic mechanical low back disorder with disc pathology and radiculopathies; and recommended thoracic and lumbar myelogram/CT scan for further investigation.

On March 12, 2008, the request for thoracic myelogram/CT scan was nonauthorized. Rationale: *The patient had recently undergone MRI imaging of the thoracic spine, which was unremarkable. The patient has no evidence of spinal cord compression or central canal stenosis at any level of the thoracic spine for the MRI dated January 2008. The patient has no evidence of progressive neurologic deficits. The patient has been shown on plain films to have an extension of screw superiorly through the superior endplate of L5 and into the L4-L5 disc. CT myelogram is not warranted. The patient is noted to have disc irritation at L4-L5 due to misplaced pedicle screws. There is insufficient clinical evidence presented to support the request for myelogram of either the thoracic or lumbar spine.*

On March 17, 2008, Dr. responded as follows: *The patient has severe upper and mid thoracic pain and upper and mid and lower lumbar pain to the point where he is incapacitated. He has had previous surgery. He has neurological deficits as noted before. He has great difficulty simply moving around. He needs these studies done so that we can be sure of the pathology and make appropriate*

decisions regarding management. He still requires hydrocodone, Effexor, and Xanax. Sedatives do not give him any benefit.

On March 29, 2008, an appeal for thoracic myelogram/CT scan was denied. Rationale: *The patient had a negative thoracic MRI in January 2008. He has never been operated on in the thoracic area before, and other than trigger points in the thoracic area, there is no complaint or finding referral to this area. The neurological examination does not suggest any thoracic pathology. This test is not medically necessary.*

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

*Medical material review for this case listed numerically included:*

- 1. A summary of medical events provided by Matutech Inc.*
- 2. Reports of a thoracic and lumbar MRI by Dr. on 3-10-2006 and another interpreted by Dr. on 1-3-2008.*
- 3. Chiropractor clinic notes of 5-23-2006.*
- 4. 1-28-2004 note by, M.D.*
- 5. 3-6-2008 report by M.D. and also a report by the same physician on 3-17-2008.*
- 6. Insurance's group letter to Dr. on 3-12-2008 and 3-21-2008 nonauthorizing a thoracic CT Myelogram.*
- 7. A letter to Ms. by on 3-27-2008.*
- 8. report of 3-21-2008 by M.D.*

*This case involves a now xx year-old male who on xx/xx/xx was knocked down by a seventy-five gallon drum and in the process twisted his back and developed low back and mid back pain. Medications, physician therapy, and epidural steroid injections were not successful in dealing with his lumbar pain and lumbar discography was positive at the L5-S1 level and this led to a 2-7-2007 anterior and posterior laminectomy with fusion at the L5-S1 level with instrumentation. There was no significant improvement with the patient's symptoms following his surgery and he continues to have pain in his low back extending into the lower extremities, especially on the left side. In addition, he has mid back pain with some extension "around the thoracic cage". An MRI of the thoracic spine done on 3-10-2006 showed mid level changes suggestive of potential nerve root compression. A repeat thoracic MRI on 1-3-2008 was interpreted as being normal. Injections in the thoracic spine in the T6-T7 and T7-T8 regions in June of 2007 gave temporary relief of the mid back pain.*

*I disagree with the denial for the proposed lumbar and thoracic myelographic evaluation. I think the lumbar evaluation is indicated by the development of pain in the left lower extremity in addition to his low back pain. Instrumentation frequently interferes with interpretation of an MRI and therefore CT myelography may give information not seen on the MRI. **The patient** continues to have pain in his mid thoracic spine region with radiation suggesting radiculopathy and therefore while contrast is present for the lumbar myelogram, it would be strongly indicated to utilize that to the mid thoracic region for evaluation of the thoracic spine in it's lower and mid portions. His symptoms according to the report by Dr.*

*in January of 2008 certainly suggest that some possibly correctable pathology is present in the thoracic spine which was not seen on MRI evaluation. In regard to the MRI evaluation variation from abnormal to normal, it is probable that if the first interpreter interpreted the second MRI he may see the same thing as he saw on the first, but with these being minimal the second interpreter probably thought this was a variation of normal or at least a normal progression of changes due to age.*

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

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

**Guidelines developed by the reviewer over 38 years of evaluating spinal surgical problems.**