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**Notice of Independent Review Decision**

**DATE OF REVIEW:**            04-08-08

**IRO CASE #:**

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

Lumbar myelogram with CT

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

Certified by the American Board of Orthopaedic 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)

Injury Date	Claim Number	Review Type	ICD9/ DSMV	HCPCS/ NDC	Overturn/ Upheld
		Prospective	722-10		Overturn

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Utilization Review Decision dated, 02-14-08 and 03-06-08  
 Medical notes dated, 03-10-07, 04-16-07, 05-10-07, 06-07-07, 08-10-07, 09-27-07, 12-27-07, and 02-07-08,  
 MRI lumbar spine dated, 03-07-07, 01-28-08  
 Operative note dated, 09-04-07  
 History & Physical dated, 09-04-07  
 Lumbar Myelogram dated, 05-25-07

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Neurological Consultation report dated, 03-13-07  
Outpatient Daily Progress Note dated, 10-12-07, 11-30-07  
Discharge Summary dated, 09-05-07  
Operative Report dated, 05-25-07  
CT evaluation of the Lumbar Spine post Myelography dated, 05-25-07  
Operative note, lumbar epidural steroid injection, dated 05-01-07  
Official Disability Guidelines (ODG): Chapter Low Back - Lumbar & Thoracic –  
Myelography

**PATIENT CLINICAL HISTORY:**

The claimant's injury occurred on xx/xx/xxxx and had onset of severe low back pain and bilateral radiating hip and leg pain. The claimant's treatment included a Medrol Dosepak, medications such as Soma and Neurontin, physical therapy and epidural steroid injection. The claimant is 5 months post laminectomy with excision of large disc fragment. MRI dated 3/7/07 notes a 2mm disc protrusion with mild bilateral neuroforaminal narrowing, and at L5-S1 a 3mm disc protrusion with mild bilateral neuroforaminal narrowing. The claimant continues to complain of chronic mechanical back pain and leg pain. The medical note of 2/7/08 indicated that a lumbar myelogram and CT scan would be requested to determine extent of root compression and need for surgery.

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

The Reviewer considered the ODG guidelines for myelography in the lumbar spine: Recommended as an option. Myelography OK if MRI unavailable.

ODG TWC Low Back - CT & CT Myelography: 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) 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

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-Myelopathy, infectious disease patient

The Reviewer cited the National Guideline Clearinghouse – Guideline Title Low back pain. Magnetic Resonance Imaging, Computed Tomography, Myelography, Myelography/CT. Myelogram/CT can be used after prior surgery or with radiculopathy.

In the professional opinion of the Reviewer, based on all information available, the requested lumbar myelogram with CT should be authorized for this claimant. The claimant as noted above is status post laminotomy (September 2007) and continues to complain of severe pain that still requires Vicodin and Soma. MRI report on 03/07/07 showed 2mm disc protrusion at L4-5. MRI dated 01-28-08 noted L4-5 broad based disc bulge with focal protrusion. A lumbar myelogram and CT scan would help determine source of any nerve root compression and need for surgery. According to the Reviewer, the claimant has combination instability / facet arthrosis syndrome and will possibly require further surgery.

In conclusion, the requested procedure lumbar myelogram with CT is medically necessary for this claimant. The Reviewer stated that it is important to note that the CT scan/myelogram is still more sensitive and specific than any MRI and remains the gold standard.

**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**

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- 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)**