

# Applied Assessments LLC

*An Independent Review Organization*  
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## Notice of Independent Review Decision

**DATE OF REVIEW:** 04/07/08

**IRO CASE #:**

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

Lumbar myelogram with post myelogram CT scan

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

M.D., 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)

Upon independent review the reviewer finds that the requested lumbar myelogram with post myelogram CT scan is not medically necessary.

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

This is a claimant who complained of low back pain and right leg pain who was injured. Apparently he had low back pain and bilateral leg pain. He had conservative modalities including physical therapy, epidural steroid injections, and spinal decompression therapy. He subsequently in August 2007 underwent a lumbar discectomy reportedly at L4/L5. His leg pain on the left improved, but his pain on the right apparently was similar or perhaps worse. He has had an MRI scan as well as an EMG study since the previous surgery, and there has been a request for a myelogram and post myelographic CT scan. There is evidence on the MRI film of significant spinal stenosis as well as centrally and neural foraminally, and there is evidence of degenerative disc disease at multiple levels. Physical examination on 02/28/08, which revealed decreased sensation in the L4/L5 and L5/S1 dermatomes on the right foot. There is noted persistent clonus but no evidence of hyperreflexia or increased muscle tone. There is indication of desire to consider surgery in this patient. However, the reasons and recommendations for that

assessment are unclear. His most recent MRI scan appears to be on 12/07/07, which revealed multilevel degenerative changes with facet arthropathy, post surgical changes, soft tissue tract for epidural infusion catheter or stimulator, no abnormal spinal cord signal, and a tiny posterior annular fissure at L5/S1. The diameter at L4/L5 of the spinal canal is stated to be 9 mm anterior posterior

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

It is unclear from the medical records what potential surgery might be proposed. While he does have central stenosis and neural foraminal stenosis, there is no clear evidence of myelopathy contained within the medical records. The use of myelography, particularly in the lumbar spine, is indicated when previous imaging studies such as MRI scan are inconclusive. This recommendation can be found in the ODG Low Back Chapter. Within the medical records available for review, there is no clear documentation of the condition for which the lumbar CT myelogram would be indicated. The MRI scan has clearly identified not only the stenosis neural foraminaly and centrally but also the annular tear. As in this case when the MRI scan is available, it is not contraindicated or inconclusive, and there is no evidence based upon the medical records that the myelogram and post CT would add information to the diagnostic trail. It is for these reasons that the previous determination concerning the CT myelogram is upheld.

**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)**