URAC ACCREDITED

CLAIMS EVAL

Utilization Review and Peer Review Services

Notice of Independent Review Decision-WC

DATE OF REVIEW: 12/29/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

CT/Myelogram of the lumbar spine with thin slices 72265, 72132, MRI of the lumbar spine with and without contrast 72158 and MRI of the left hip 73721

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

American Board of Orthopaedic Surgery-Board Certified

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- 2-14-02 MRI of the lumbar spine
- 2-26-02 surgery performed by , MD.
- 4-16-02 , MD., office visit.
- 3-3-03 , MD., office visit.
- 5-16-05 , MD., office visit.
- 6-3-05 MRI of the lumbar spine
- 6-17-05 , MD., office visit.
- 11-20-08 , MD., office visit.
- 12-1-08 , MD., Utilization Review.
- 12-9-08 , MD., Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

On 2-14-02, an MRI of the lumbar spine revealed multilevel disc desiccative changes at L1-L2, L2-L3 and L3-L4. Annular bulges at L2-L3, L4-L5 and L5-S1. Small, left posterolateral disc herniation at L3-L4, involving the medial neural foramina.

On 2-26-02, the claimant underwent lumbar L3-L4 laminectomy, medial facetectomy and foraminotomies, L3-L4 discectomy, left L3-L4 posterolateral instrumented fusion with local autograft performed by , MD.

On 3-3-03, the claimant was evaluated by , MD. The claimant is at one year post op and has returned to his regular activities. The claimant's left lower extremity radicular pain has completely resolved. The claimant does have some mild persistent numbness over the left medial knee. On exam, the claimant has normal heel to toe gait. Motor strength is 5/5 throughout both lower extremities. Sensation is intact. SLR is negative. X-rays of the lumbar spine revealed L3 wide laminectomy with L3-L4 uninstrumented posterolateral fusion. Lumbar spine is stable on flexion and extension views. The claimant was continued with his work duties without restrictions.

On 4-16-02, the claimant was evaluated by Dr. . The claimant does not have any complaints of axial back pain. The claimant reported his left lower extremity radicular pain has improved dramatically. The claimant continues to have some mild left anterior thigh numbness. On exam, there is a posterior midline lumbar incision is well-healed. Lumbar range of motion from extension to 10 degrees and flexion to 40 degrees is pain-free. Right lower extremity motor strength is 5/5 throughout. Sensation is diminished to the left anterior thigh and left medial knee. Right straight-leg raising is entirely negative. Left straight-leg raising is positive at 60-70 degrees. The evaluator noted the claimant was progressing quite well. His left lower extremity radicular symptoms are dramatically improved. The claimant was continued with his TSO brace for an additional six weeks time.

A follow-up visit with Dr. dated 5-16-05 noted the claimant has occasional pain that radiates to the end of the buttock and rarely down the end of the leg. The claimant has been on Celebrex and does not do much for him. Due to the claimant consistent pain, the evaluator recommended an MRI of the lumbar spine.

On 6-3-05, an MRI of the lumbar spine revealed multilevel degenerative change and discogenic disease. No focal disc herniation, mild chronic ventral compression deformities of T11 and T12.

Follow-up visit with Dr. on 6-17-05 noted the claimant's symptoms are unchanged. On exam, the claimant has no focal, motor or sensory deficits. The claimant was referred for some physical therapy.

On 11-20-08, the claimant was evaluated by , MD. The claimant is noted to be xx-years-old who presents with low back pain and recent onset of left lower extremity pain for the past three months. The pain is traveling down the anterior thigh on the left and down the inferomedial aspect of the thigh going into the knee with a burning sensation in the same distribution. On exam, the claimant has SLR negative on both sides, but the femoral nerve stretch test was markedly positive on the left with anterior thigh pain reproduced. Neurological testing was full in all lower extremity myotomes. Sensation is intact in all lower extremities. DTR were within normal limits. X-rays of the lumbar pine revealed prior attempt of fusion at L4-L5 but no evidence of bridging bone in either posterolateral gutter. No convincing evidence of continuous bony bridging is seen. There is grade I spondylolisthesis of L5 on S1 below the fused segment with evidence of what appears to be spine bifida occulta. The evaluator recommended further evaluation to include CT myelogram and lower extremity electrodiagnostic testing.

12-1-08 , MD., provided an adverse determination for the request of CT/Myelogram of the lumbar pine, MRI of the lumbar spine and MRI of the left hip.

12-9-08 , MD., provided an adverse determination for the request of CT/Myelogram of the lumbar spine, repeat MRI of the lumbar spine and MRI of the left hip.

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

THE REQUEST FOR A LUMBAR MYELOGRAM/CAT SCAN AND MRI SHOULD NOT BE APPROVED. I WOULD AGREE WITH THE PRIOR DENIALS.

CLAIMANT IS NOW 6 YEARS POST OP FUSION WITH INSTRUMENTATION. WHILE THERE IS NO RADIOLOGICAL EVIDENCE OF A POSTERIOR/LATERAL FUSION, THERE IS FIBROSIS IN THE LATERAL GUTTERS. THERE IS MEDICAL LITERATURE THAT HAS SHOWN THE PRESENCE OF A PSEUDOARTHROSIS DOES NOT PREDICT THE OUT COME FROM A LUMBAR FUSION. THERE IS NO EVIDENCE OF INSTABILITY AT L3/L4.

CLAIMANT HAD A LUMBAR MRI IN 2005 (3 YEARS POST FUSION) WITH POST SURGICAL CHANGES AND DEGENERATIVE CHANGES. ANY FINDINGS ON A MYELOGRAM/CAT WOULD BE RELATED TO A PROGRESSIVE DEGENERATIVE PROCESS OF AGING.

THE RECORDS PROVIDED DO NOT DOCUMENT A PLAIN X-RAY OF THE LEFT HIP, WHICH WOULD BE THE BASIC INITIAL EVALUATION OF HIP DISEASE. THERE IS NO DOCUMENTATION OF A HIP INJURY AS RELATED TO THE WORK INJURY OF 2002. THEREFORE, THE REQUEST FOR CT/MYELOGRAM OF THE LUMBAR SPINE WITH THIN SLICES 72265, 72132, MRI OF THE LUMBAR SPINE WITH AND WITHOUT CONTRAST 72158 AND MRI OF THE LEFT HIP 73721 IS NOT CERTIFIED.

ODG-TWC, last update 12-20-08 Occupational Disorders of the Low back - Lumbar and Thoracic:

Indications for imaging -- Magnetic resonance imaging:
- Thoracic spine trauma: with neurological deficit
- Lumbar spine trauma: trauma, neurological deficit
- Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit)
- Uncomplicated low back pain, suspicion of cancer, infection
- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. (For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.) (Andersson, 2000)
- Uncomplicated low back pain, prior lumbar surgery
- Uncomplicated low back pain, cauda equina syndrome
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, painful
- Myelopathy, sudden onset
- Myelopathy, stepwise progressive
- Myelopathy, slowly progressive

- Myelopathy, infectious disease patient
- Myelopathy, oncology patient

Lumbar CT and CT post 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) (Chou, 2007) 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) The new ACP/APS guideline as compared to the old AHCPR guideline is more forceful about the need to avoid specialized diagnostic imaging such as computed tomography (CT) without a clear rationale for doing so. (Shekelle, 2008)
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
- Evaluate pars defect not identified on plain x-rays
- Evaluate successful fusion if plain x-rays do not confirm fusion (Laasonen, 1989)

ODG-TWC, last update 12-29-08 Occupational Disorders of the Hip and Pelvis - MRI of the Hip:

Indications for imaging -- Magnetic resonance imaging:
Osseous, articular or soft-tissue abnormalities
Osteonecrosis
Occult acute and stress fracture
Acute and chronic soft-tissue injuries
Tumors
Exceptions for MRI
Suspected osteoid osteoma (See CT)
Labral tears (use MR arthrography)

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)**