



# PROFESSIONAL ASSOCIATES

## Notice of Independent Review Decision

**DATE OF REVIEW:** 06/04/08

**IRO CASE #:**

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

Thoracic myelogram

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

Board Certified 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)

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.

Thoracic myelogram - Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

A Supplement to a TWCC-61 form from, M.D. dated 04/04/05  
TWCC-73 forms from Dr. dated 04/04/05, 04/11/05, and 04/18/05  
Evaluations with Dr. dated 04/11/05 and 04/18/05  
A physical therapy evaluation with, P.T. dated 04/05/05  
Evaluations with, D.C. dated 04/22/05, 05/24/05, 06/29/05, and 11/21/05  
TWCC-73 forms from Dr. dated 04/22/05, 05/24/05, 06/06/05, 06/29/05, and 11/21/05  
Chiropractic therapy with Dr. dated 04/25/05, 04/26/05, 04/27/05, 04/28/05, 05/02/05, 05/03/05, 05/04/05, 05/05/05, 05/09/05, 05/10/05, 05/11/05, 05/12/05, 05/16/05, 05/17/05, 05/18/05, 05/19/05, 05/23/05, 05/25/05, 05/31/05, 06/01/05, 06/02/05, 06/06/05, 06/07/05, 08/08/05, 09/13/05, 09/28/05, and 10/27/05  
An EMG/NCV study interpreted by, M.D. dated 04/29/05  
An MRI of the lumbar spine interpreted by, M.D. dated 05/10/05  
Evaluations with, M.D. dated 06/03/05, 07/01/05, 07/05/05, 07/11/05, 08/10/05, 10/18/05, 10/26/05, 11/01/05, 11/08/05, and 11/18/05  
TWCC-73 forms from Dr. dated 06/03/05 and 11/18/05  
A referral note from Dr. dated 08/08/05  
A peer review from, D.C. dated 06/20/05  
An evaluation with, M.D. dated 08/25/05  
A letter of non-certification, according to an unknown source, from D.O. dated 09/06/05  
An MRI of the dorsal spine interpreted by Dr. dated 10/19/05  
Evaluations with, M.D. dated 12/21/05, 04/25/07, 05/31/07, 07/06/07, 09/11/07, 10/10/07, 02/13/08, 03/05/08, and 04/09/08  
Designated Doctor Evaluations with, M.D. dated 04/17/06 and 03/24/08  
An evaluation with, D.C. dated 03/02/07  
Evaluations with an unknown provider (no name or signature was available) dated 03/02/07 and 03/27/07  
An MRI of the lumbar spine interpreted by, M.D. dated 09/27/07  
An operative report from Dr. dated 01/22/08  
A Decision and Order from TDI dated 03/20/08  
An MRI of the thoracic spine interpreted by, M.D. dated 03/21/08  
A Functional Capacity Evaluation (FCE) with, M.D. dated 03/26/08  
An MRI of the cervical spine interpreted by Dr. dated 04/09/08  
A letter of non-certification, according to the ODG, from, M.D. dated 04/23/08  
A letter of non-authorization, according to the ODG, from, M.D. dated 05/05/08  
The ODG Guidelines were not provided by the carrier or the URA

## **PATIENT CLINICAL HISTORY**

On 04/04/05, Dr. recommended Lodine and physical therapy. Chiropractic therapy was performed with Dr. from 04/25/05 through 10/27/05 for a total of 27 sessions. An EMG/NCV study interpreted by Dr. on 04/29/05 was normal. An MRI of the lumbar spine interpreted by Dr. on 05/10/05 revealed a disc herniation at L5-S1 with extension behind the L4 vertebral body and mild stenosis at L4-L5. On 06/03/05, Dr. recommended a Medrol Dosepak and Celebrex. On 06/20/05,

Dr. recommended continued chiropractic therapy. On 08/25/05, Dr. recommended a lumbar myelogram. On 09/06/05, Dr. wrote a letter of non-certification for a lumbar myelogram. An MRI of the thoracic spine interpreted by Dr. on 10/19/05 revealed degenerative disc disease and a disc herniation at T7-T8. On 10/26/05 and 11/08/05, Dr. recommended thoracic epidural steroid injections (ESIs). On 12/21/05, Dr. also recommended an ESI. On 04/17/06, Dr. placed the patient at Maximum Medical Improvement (MMI) with a 0% whole person impairment rating. On 07/06/07, Dr. recommended a discogram CT scan. An MRI of the lumbar spine interpreted by Dr. on 09/27/07 revealed a disc protrusion at L4-L5. On 10/10/07, Dr. recommended lumbar spine surgery. Lumbar spine surgery was performed by Dr. on 01/22/08. On 02/13/08, Dr. recommended physical therapy. On 03/20/08, a Decision and Order determined the compensable injury extended to include a thoracic spine sprain and herniated disc at T7-T8. An MRI of the thoracic spine interpreted by Dr. on 03/21/08 was unremarkable. On 03/24/08, the patient was placed at MMI as of 03/21/07 with a 15% whole person impairment rating. Based on an FCE with Dr. on 03/26/08, the patient could function at least at a sedentary physical demand level. An MRI of the cervical spine interpreted by Dr. on 04/09/08 revealed a small disc protrusion at C5-C6. On 04/09/08, Dr. recommended Lyrica, discontinuation of Neurontin and Hydrocodone, a possible bone scan, and a possible myelogram CT scan of the thoracic spine. On 04/23/08, Dr. wrote a letter of non-authorization for a thoracic myelogram. On 05/05/08, Dr. also wrote a letter of non-authorization for a myelogram CT scan.

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

The patient does not have any evidence of thoracic radiculopathy. This patient had a lumbar sprain/strain with mild degenerative changes at the L4-L5 level. He underwent anterior lumbar interbody fusion. He has had complaints in the mid thoracic spine. The thoracic MRI was repeated and was totally normal. Therefore, repeating a diagnostic study is neither reasonable nor necessary.

According to the ODG, the clinical criteria for performing a secondary neurologic imaging study such as a CT myelogram or repeating an MRI would be increasing neurologic dysfunction. The patient does not have any evidence of thoracic radiculopathy. Thoracic myelography will not elucidate the source of his thoracic pain. He is not a further surgical candidate. Therefore, according to the ODG and most current spinal textbooks, the patient is not a candidate for further imaging.

Based on the logic above, using the criteria promulgated by the ODG and current medical textbooks, the requested thoracic myelogram is neither reasonable nor necessary. I am aware of the decision that has indicated that the patient

sustained a thoracic strain at the time of injury; nonetheless, this study is neither reasonable nor necessary.

**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 AND KNOWLEDGE BASE
- 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)