



# PROFESSIONAL ASSOCIATES

## Notice of Independent Review Decision

**DATE OF REVIEW:** 06/19/08

**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**

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.

Lumbar myelogram with post myelogram CT scan - Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

An MRI of the lumbar spine interpreted by an unknown provider (no name or signature was available) dated 02/01/08

An evaluation with an unknown provider (signature was illegible) dated 02/22/08  
A Functional Capacity Evaluation (FCE) with an unknown provider (no name or signature was available) dated 02/26/08  
An evaluation with M.D. dated 04/08/08  
A letter of non-certification, according to the ODG, from M.D. dated 04/22/08  
Letters of non-certification, according to the ODG, from D.O. dated 05/16/08 and 05/19/08  
The ODG Guidelines were not provided by the carrier or the URA

### **PATIENT CLINICAL HISTORY**

An MRI of the lumbar spine interpreted by an unknown provider on 02/01/08 revealed disc desiccation at L1-L2 and mild facet hypertrophy with a small amount of fluid in the right facet joint at L3-L4. The unknown provider referred the patient to a back specialist on 02/22/08. An FCE with an unknown provider on 02/26/08 indicated the patient functioned at the light physical demand level. On 04/08/08, Dr. recommended a lumbar myelogram with CT scan. On 04/22/08, Dr. wrote a letter of non-authorization for the lumbar myelogram with CT scan. On 05/16/08 and 05/19/08, Dr. wrote letters of non-authorization for the lumbar myelogram with CT scan.

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

This patient had a heavy weight fall on her. At worst, this would have created a contusion or a sprain/strain to the back. She had an MRI obtained that did not demonstrate any significant neurological compression. The ODG recommends repeating imaging studies only in the event of an acute neurological change. CT myelography is not reasonable except in limited circumstances where the MRI has not given an appropriate response. This claim has been reviewed by a neurosurgeon, as well as an orthopedic spine surgeon. They both agree that there is no indication for a CT myelogram and in my opinion, the ODG does not permit the CT myelogram either.

In this patient, in the absence of any significant neurological deficit, an electrodiagnostic study showing objective evidence of radiculopathy, and no changes in the patient's condition, there is no reason to repeat the CT myelogram once a negative MRI was obtained. Therefore, the requested lumbar myelogram with post myelogram CT scan 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)

DWC Lower Back criteria for CT myelography