

# IRO Express Inc.

An Independent Review Organization

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**DATE OF REVIEW:** 06/16/2008

**IRO CASE #:**

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

Myelogram and post-myelogram CT with X-rays

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

**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)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male with a date of injury xx/xx/xx while driving a forklift and hitting a pothole. He has had physical therapy and epidural steroid injections. An MRI of the lumbar spine 06/01/2007 revealed left paracentral disc bulge at L4-L5 with left lateral recess stenosis and neuroforaminal compromise. A myelogram performed 01/21/2008 revealed a left paracentral disc herniation with left L5 nerve root impingement. The patient underwent a left L4-L5 microdiscectomy on 02/29/2008 and did well. On 03/06/2008 he had recurrence of low back and left leg pain. He completed a medrol-dose pack and felt better for a while. He now has left leg pain that goes into his foot. His neurological examination reveals weakness in the left quads muscle. A CT scan of the lumbar spine 04/21/2008 with IV contrast reveals enhancing soft tissue density encasing the proximal left L5 nerve root. There is also a 3-4mm diffuse soft-tissue structure in the ventral epidural space at L4-L5. The provider is recommending a lumbar myelogram with post-myelogram CT, as well as lumbar flexion and extension x-rays to rule-out instability.

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

The lumbar myelogram with post-myelo CT is not medically necessary. If the provider suspects a recurrent disc herniation, then ODG recommends a MRI of the lumbar spine with and without contrast is what is needed initially. Also, there is no documentation of mechanical back pain or a spondylolisthesis to suggest instability; therefore, the lumbar flexion and extension films are also not medically necessary.

**References/Guidelines**

2008 *Official Disability Guidelines*, 13th edition:  
“Low Back” chapter:

**MRI:** “MRI’s are test of choice for patients with prior back surgery”.

**Flexion/extension imaging studies:** “For spinal instability, may be a criteria prior to fusion, for example in evaluating symptomatic spondylolisthesis when there is consideration for surgery.”

**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)