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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 06/12/2008

IRO CASE #:

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

This case was reviewed by a Pain Management, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar myelogram and post myelogram CT scan of the lumbar

spine **REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

UPHELD (Agree)

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews available for my review, the patient is general laborer employee who sustained an industrial injury to the lumbar spine on xx/xx/xx.

Lumbar MRI of September 26, 2007 performed for lower back pain with radiculopathy and weakness shows mild canal narrowing at L3-4 and L4-5 secondary to a combination of posterior disc bulging, bilateral facet hypertrophy and ligamentum flavum thickening without evidence of disc protrusions and mild neuroforaminal narrowing within the lower lumbar spine.

Nerve conduction studies were performed on October 23, 2007 and interpreted as showing evidence of L4 and L5 radiculopathy on the right and left. Peripheral neuropathy of the bilateral lower extremities could not be ruled out.

An orthopedic surgical consultation was provided on November 21, 2007. The patient reports low back pain of 5-6/10 and bilateral leg pain since carrying buckets and falling down three or four steps 60 days prior. Physical therapy did not help and medications provided slight help. He reports leg tingling and numbness. On examination, the patient demonstrates antalgic gait, restricted lumbar range of motion and positive right quadrant L5 facet loading. Lower extremity strength in the anterior tibialis,

hamstring and gastrocs is 4/5 on the left. Left L4, L5 and S1 sensation is abnormal. Straight leg raising is positive bilaterally. Imaging and examination suggest facet mediated pain, right greater than left at L4, L5. Recommendation is for facet block on the right.

A neurosurgical consultation was provided on February 2, 2005. The patient had not progressed with 5 months of conservative treatment. EMG/NCV shows bilateral L4 and L5 radiculopathy. MRI shows contained disc herniation rated as stage II with annular herniation, nuclear protrusion and spinal stenosis with disc dessication at L3-4, L4-5 and L5-S1. The examination was significant for positive Braggard's on the left and some weakness of the gastro-soleus on the left. The assessment states there is instability at L5-S1. Recommendation was for decompression and discectomy at L3-4 and L4-5 and decompression and stabilization at L5-S1, as this level was stated to be unstable.

The patient was seen on March 11, 2008 by his primary provider. The patient has increased pain and has to flex his knee and walk around the office as he waits. Preauthorization for a surgical intervention is pending.

A request for surgical intervention was not certified in review on March 14, 2008 with rationale that per an orthopedic surgical consultation of November 21, 2007, the patient was not a surgical candidate and had facet mediated pain. The reviewer considered the x-ray films in his opinion. The current provider states the patient is grossly unstable with 6 mm of motion at the L5-S1 segment with 29 degrees of angular deformity per the x-rays. The patient had also not passed psychological assessment as required by guidelines for a fusion procedure.

Request for appeal was made on March 31, 2008 for a surgical intervention with rationale that a fusion procedure is requested at one level, not two levels as stated in the adverse determination report. Implantation of a bone growth stimulator was also requested.

The patient was assessed on March 21, 2008 for appropriateness of lumbar spine surgery. The patient was fearful of surgery and was hesitant to proceed and was therefore determined not an appropriate candidate.

The appeal for reconsideration of a surgical intervention including fusion at L5-S1 was not certified on April 7, 2008 with rationale that ODG does not support discectomy and fusion unless there is failure of 6 months of conservative treatment and severe structural instability and/or acute progression of neurologic dysfunction. Per the provider's office assistant, the patient now desires to proceed with a surgical intervention. Additional information would be needed before a positive response could be made.

On May 5, 2008 a request was made for preauthorization of lumbar myelogram and post myelogram CT scan of the lumbar spine.

Request for myelogram and post myelogram CT scan of the lumbar spine was not certified in review on May 9, 2008 with rationale that the medical necessity for the request was not established. There was no indication that the results of such a diagnostic assessment would affect a treatment plan. Myelography is invasive and painful and guidelines note that it has largely been replaced by noninvasive magnetic resonance imaging. In addition, the ODG references cited did not support the medical necessity of the request. A peer-to-peer discussion was attempted but not realized.

A request for reconsideration for lumbar myelogram and post myelogram CT scan was not certified in review on May 22, 2008 with rationale that, per guidelines, MRI has largely replaced the invasive and painful myelography procedures. In addition, the patient did not meet guideline criteria to warrant CT scan such as acute trauma, suspect fracture, myelopathy, traumatic myelopathy or need to evaluate a pars defect not identified on plain films. It was noted that sufficient diagnostic information has been obtained for a surgeon to determine a need for surgery.

On May 27, 2008 the provider requested an IRO.

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

The medical records document lumbar disc bulging without protrusions per MRI and bilateral radiculopathy per nerve conduction studies and signs of disc but primarily facet mediated pain per an orthopedic consultation. There was reported left-sided

weakness and instability with 6 mm of motion at the L5-S1 segment at L5-S1 per neurosurgical consultation and radiographs, and a request for surgery including fusion was made. In review, the x-ray films were apparently incorrectly read and gross instability was not consistent with prior evaluation and opinion of facet mediated pain. In addition, a psychological assessment had not been provided and the patient was fearful to proceed. The intervention was requested again clarifying that fusion is planned at just one level not two. In an attempt of a peer-to-peer discussion, it was learned the patient now desires to proceed. Reconsideration was not granted due insufficient information. There followed, the current request for invasive diagnostic imaging of myelogram and post myelogram CT scan. The rationale for the request was not established and the request was not certified. A second request was also denied as MRI has largely replaced the invasive and painful myelography procedures. In addition, the patient did not meet guideline criteria to warrant CT scan such as acute trauma, suspect fracture, myelopathy, traumatic myelopathy or need to evaluate a pars defect not identified on plain films. It was noted that sufficient diagnostic information has been obtained for a surgeon to determine a need for surgery.

ODG is quite clear on use of myelography. The indications are cited below. To warrant lumbar myelography there must be evidence of recent trauma with neurological deficit, suspicion of a chance fracture from a seatbelt, traumatic myelopathy, infectious myelopathy, need to evaluate a pars defect not seen on plain films or need to evaluate a fusion. The medical records fail to document criteria required by guidelines to warrant myelography. In addition, as MRI and nerve conduction studies have been performed and sufficient information was available for a decision regarding surgery, the rationale for additional invasive intervention of myelography has not been clarified. Therefore, my determination is to agree with the previous non-certification of the request for lumbar myelogram and post myelogram CT scan of the lumbar spine.

The IRO's decision is consistent with the following guidelines:

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 KNOWLEDGBASE
- 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
- X 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

The Official Disability Guidelines – Lumbar Myelogram – 05/30/2008:

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)