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DATE OF REVIEW: 04/24/09

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

X-rays of the lumbosacral spine interpreted by, M.D. dated 05/18/04
MRIs of the lumbar spine interpreted by, M.D. dated 06/18/04 and 11/02/05
A lumbosacral myelogram CT scan interpreted by Dr. (no credentials were listed) dated 08/23/04

X-rays of the right hip interpreted by Dr. dated 11/17/04

An EMG/NCV study interpreted by, M.D. dated 12/03/04

A lumbar discogram performed by, M.D. dated 01/26/05
A post discogram CT scan interpreted by, M.D. dated 01/26/05
A prescription from Dr. dated 02/12/05
Evaluations with M.D. dated 02/14/05, 05/22/08, 11/24/08, 02/16/09, and 03/10/09
An operative report from Dr. dated 09/12/05
Evaluations with, M.D. dated 12/12/05 and 01/15/09
A request for reconsideration letter from Dr. dated 03/31/06
A lumbar myelogram CT scan interpreted by Dr. dated 11/29/06
A letter of non-certification, according to the Official Disability Guidelines (ODG), from, M.D. dated 02/05/09
A letter from, D.C. dated 02/19/09
A preauthorization request for a lumbar myelogram CT scan from Dr. dated 02/19/09
A letter of non-certification, according to the ODG, from, M.D. dated 03/06/09
An EMG/NCV study interpreted by, M.D. dated 03/10/09
A review of medical records and an evaluation from Dr. dated 03/20/09
The ODG Guidelines were provided by the carrier or the URA

PATIENT CLINICAL HISTORY

X-rays of the lumbosacral spine interpreted by Dr. on 05/18/04 revealed mild disc space narrowing at L5-S1 and mild bilateral facet osteoarthritis at L4-L5 and L5-S1. An MRI of the lumbar spine interpreted by Dr. on 06/18/04 revealed a disc protrusion at L3-L4, a disc bulge at L4-L5, and mild facet arthrosis at L5-S1. A lumbar myelogram CT scan interpreted by Dr. on 08/23/04 revealed a mild L3-L4 disc bulge only. X-rays of the right hip interpreted by Dr. on 11/17/04 were unremarkable. An EMG/NCV study interpreted by Dr. on 12/03/04 revealed severe bilateral sensory and motor peripheral neuropathy probably from diabetes. A lumbar discogram interpreted by Dr. on 01/26/05 revealed concordant pain at L3 through S1. A post discogram CT scan interpreted by Dr. on 01/26/05 revealed degenerative disc disease at L5-S1, facet arthropathy, and annular tears at L2 through L5. On 09/12/05, Dr. performed a bilateral SI joint radiofrequency neurotomy at S1-S5 and at the right sensory femoral/obturator. An MRI of the lumbar spine interpreted by Dr. on 11/02/05 showed disc protrusions at L3-L4 and L4-L5. On 12/12/05, Dr. recommended a possible discogram and pain pump trial. A lumbar myelogram CT scan interpreted by Dr. on 11/29/06 showed disc bulges at L2-L3 and L4-L5 and a disc protrusion at L3-L4. On 05/22/08, Dr. recommended lumbar spine surgery. On 02/05/09, Dr. wrote a letter of non-certification for a lumbar myelogram CT scan. On 03/06/09, Dr. also wrote a letter of non-certification for a lumbar myelogram CT scan. An EMG/NCV study interpreted by Dr. on 03/10/09 revealed acute and chronic bilateral L5 lumbosacral radiculopathy. On 03/20/09, Dr. recommended a lumbar myelogram CT scan.

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

Further imaging is not indicated in this patient's condition. He does not have the onset of any objective neurological findings. New neural imaging will not change his condition. Further, the ODG does not recommend a CT myelogram when an MRI is available and could be performed (there are no contraindications in this patient to MRI). Therefore, on two counts, the lack of medical necessity and the fact that the ODG recommends an MRI, the CT myelogram is neither reasonable nor necessary.

Specifically, the ODG states lumbar myelogram is okay if MRI is unavailable, contraindicated, or inconclusive. MRI has largely replaced CT scanning and on the basis evaluation of patients with myelopathy secondary to superior soft tissue resolution. Guidelines are more forceful about the need to avoid doing specialized diagnostic testing such as CT without a clear rationale for doing so. The patient does not meet the criteria that the ODG specifies for the performance of a CT myelogram with post myelogram CT scan and therefore, the previous adverse determinations are upheld.

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)**