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Notice of Independent Review Decision

DATE OF REVIEW: 4/8/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

CT myelogram, lumbar with flexion and extension, r/o pseudoarthrosis, assess adjacent level

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

Certified by the American Board of Orthopaedic Surgery

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	724.2	72131	Upheld
		Prospective	724.2	72265	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Physician letter dated 3/12/09

Physician note dated 2/16/09

Medical Evaluation dated 2/11/09

Official Disability Guidelines provided Low Back – Myelography

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PATIENT CLINICAL HISTORY:

This claimant sustained a lumbar spine injury in xxxx. Treatment has included surgery, multiple medications, and pain management modalities. According to the 3/12/09 note a CT is necessary as MRI cannot be performed secondary to the implants. The documentation provided for review included a reference to pseudoarthrosis. A medical evaluation noted the history and presenting complaints. The physical examination noted changes consistent with the surgery performed. However, there was no competent, objective and independently confirmable medical evidence presented of a verifiable radiculopathy of spinal instability or pseudoarthrosis. Medications were endorsed.

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

As per the Division mandated Official Disability Guidelines, CT-myelogram is “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](#)) A new meta-analysis of randomized trials finds no benefit to routine lumbar imaging (radiography, MRI or CT) for low back pain without indications of serious underlying conditions, and recommends that clinicians should refrain from routine, immediate lumbar imaging in these patients. ([Chou-Lancet, 2009](#))”

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](#))

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Thus, when considering the above and given the lack of documentation of any real clinical data from the physician, the requirements for a myelogram with CT scan as noted by the Division mandated Official Disability Guidelines are not met.

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)