

P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211

Ph: (323)556-0555 Fx: (323)556-0556

DATE OF REVIEW: 04/18/09

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 (Board Certified), 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 with post CT scan

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o June 5, 2007 Electrodiagnostic studies per report Dr.
- o Sep 2007 - Oct 2008 Patient history notes, 3 pages from Dr.
- o October 24, 2007 Repeat electrodiagnostic studies per report Dr.
- o April 4, 2008 Lumbar MRI interpreted by Dr.
- o November 11, 2008 Follow-up consultation note from Dr
- o December 18, 2008 Follow-up consultation note from Dr.
- o January 15, 2009 Follow-up consultation note from Dr.
- o January 20, 2009 Follow-up consultation note from Dr.
- o January 27, 2009 Follow-up consultation note from Dr
- o February 5, 2009 Letter of non-certification
- o March 2, 2009 Letter of non-certification for reconsideration
- o March 16, 2009 Follow-up consultation note from Dr.
- o April 14, 2009 Request for IRO
- o April 16, 2009 Follow-up consultation note from Dr.
- o April 15, 2009 IRO Assignment letter
- o April 22, 2009 Letter from attorney

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records submitted for review, the patient is a female who sustained an injury to the lumbar spine on xx-xx-xx. He is followed with pain management for ongoing back pain with pain into the lower extremities, right greater than left and a diagnosis of lumbar intervertebral disc and lumbar radiculitis. An MRI of January 23, 2007 reportedly shows very mild annular bulging and facet arthropathy without stenosis at L5-S1. Repeat MRI of June 14, 2007 reportedly shows a 2 mm paracentral disc at the L5-S1 level on the right. EMG of June 5, 2007 gave impression of bilateral L3, L4, L5 and S1 radiculopathy. Updated electrodiagnostic studies of October 24, 2007 show left L5-S1 radiculopathy. An updated lumbar MRI of April 4, 2008 shows an unremarkable study.

Office notes of January 30, 2008 state the patient is pending weight bearing MRI, discogram and myelogram. The patient is being seen for low back pain ranging from 6-7/10. He reports right leg numbness and falling asleep of his leg.

At follow-up on November 11, 2008 the provider indicated the patient underwent an outside examination at the request of the insurance company. Psychological testing was included which showed no contraindications for elective surgery or discogram. It appears a myelogram has been recommended and this will be further clarified. The physical examination remains unchanged. There is a positive straight leg raise, not further clarified.

The medical report of December 18, 2008 indicates the patient has been recommendation for a CT myelogram of his lumbar spine by two surgeons. He is using Zanaflex, Hydrocodone and Lunesta. At this visit, the patient denies any weakness, fatigue, weight loss or insomnia. The patient is noted to have a history of diabetes-diet controlled. Blood pressure is noted as 144/109. There is a positive straight leg raise, not further clarified. There is sensory change in the S1 dermatome on the left, however the patient appears to be neurologically intact.

On January 15, 2009 the patient is recommended for lumbar myelogram and a psychological evaluation is planned in regard to the request. Blood pressure is noted as 159/91. The examination remains unchanged. Vicodin is refilled. On January 20, 2009 then patient reports persisting lower back pain, mostly on the right and extending into the right leg in what appears to be the L5 distribution. He is receiving medication and recently completed a chronic pain management program. He has been assigned an impairment of 5%.

At reevaluation on January 20, 2009 MRI findings were reviewed. The patient continues to experience lower back pain which is mainly located in the center of the lumbar spine and over the right lumbar area. The pain extends into the right leg in the L5 dermatome. He has requested a change of provider to be managed by this office.

The patient was seen on January 27, 2009 in follow-up. He has been assigned an impairment of 5%. Recommendation is for electrodiagnostic studies with a neurologist to further clarify his impairment. On examination, there is good functional range of motion but discomfort.

The patient was seen in follow-up on March 16, 2009 for low back pain with associated leg pain. He reports persisting pain into the right leg with numbness in the entire leg. He reports some loss of leg function. Blood pressure is 148/97. Seated straight leg raise elicits lower back pain. Straight leg raise elicits low back pain at 45 degrees. There is tenderness to palpation in the lumbar musculature. He has functional range of motion but discomfort with motion. Reflexes and motor power are normal. Sensory change is reported in the lateral leg. Return in 30 days.

Request for lumbar myelogram with post CT scan was not certified in review on February 5, 2009 with rationale that symptoms are reported as persisting without progressive findings. As no surgery has been agreed to or scheduled the medical rationale for a third imaging is unclear. Per ODG repeat MRIs are indicated only if there has been progression of neurologic deficit. Guidelines also note that the ease with which MRI depicts expansion and compression of the spinal cord in the myelopathic patient may lead to false positive examinations and inappropriately aggressive therapy if finding are interpreted incorrectly. The new ACP/APS guidelines as compared to the old AHCPDR guidelines is more forceful about the need to avoid specialized diagnostic imaging such as MRI.

Request for reconsideration of lumbar myelogram with post CT scan was not certified in review on March 2, 2009 following a peer-to-peer discussion with the provider with rationale that MRI 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. The MRI and EMG show L5-S1 pathology already and corroborate each other. Also, disc replacement for which this test is suggested is not recommended per ODG.

The patient was reevaluated on March 16, 2009. He reports his entire right leg goes numb and he losses function. Straight leg raise elicits low back pain at 45 degrees. Double straight leg raise elicits low back pain at 40 degrees.

The provider reevaluated the patient on April 16, 2009. The patient is reported to have difficulties with activities of daily living. He is considering a contested case hearing with assistance of an attorney in regard to denial of lumbar myelogram.

Per an attorney letter of April 22, 2009 the patient's providers are considering surgical intervention which has not been mentioned in previous reports or included in pre-authorization requests.

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

The medical records indicate the patient is placed at 5% impairment in July 2007. Per RME opinions, no additional physical therapy needed and the patient can be managed with non-narcotic pain medication, perhaps a muscle relaxant and a non-steroidal anti-inflammatory medication. The patient has two MRIs and an EMG showing the anatomy and nerve function. ODG supports CT myelography only when MRI is not available or there are special needs for pre-surgical planning or other

special needs, conditions not specifically documented in the reports submitted with the request. Given the availability of MRI and the studies already performed, the medical records fail to document a medical necessity for additional imaging with myelography. Therefore, my recommendation is to agree with the previous non-certification of the request for lumbar myelogram with post CT scan.

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 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
- 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 - Low Back Chapter (3-17-2009) Myelography:

Recommended as an option. Myelography OK if MRI unavailable. (Bigos, 1999)

CT Scan - Myelography

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)