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## Notice of Independent Review Decision

### IRO REVIEWER REPORT – WC (Non-Network)

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**DATE OF REVIEW:** 08/13/09

**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**

Evaluations with M.D. dated 07/03/07, 10/19/07, 01/02/08, 01/09/08, 04/09/08, 04/28/08, 05/28/08, 06/06/08, 08/26/08, 11/24/08, 02/12/09, and 02/26/09

An MRI of the lumbar spine interpreted by Dr. (no credentials were listed) dated 10/15/07

A procedure note from M.D. dated 11/07/07

A letter of approval, according to the Official Disability Guidelines (ODG), from M.D. dated 01/02/08

A chronic pain evaluation with Psy.D. dated 03/07/08

Lumbar myelogram CT scans interpreted by Dr. dated 03/19/08 and 09/17/08

A letter of approval for a CT scan of the lumbar spine from Intracorp dated 04/23/08

A lumbosacral CT scan interpreted by Dr. dated 04/28/08

Letters of non-certification from Intracorp dated 05/29/08, 06/11/08, 06/24/08, 11/03/08, and 07/22/09

An operative report from Dr. dated 07/08/08

An EMG/NCV study interpreted by M.D. dated 08/26/08

Evaluations with M.D. dated 03/27/09 and 05/16/09

A DWC-73 form from Dr. dated 03/27/09

An MRI of the lumbar spine interpreted by Dr. (no credentials were listed) dated 04/24/09

A letter from Dr. dated 06/01/09

Evaluations with M.D. dated 06/22/09 and 07/06/09

DWC-73 forms from Dr. dated 06/22/09 and 07/22/09

A progress report from Intracorp dated 06/26/09

An evaluation with M.D. dated 07/01/09

A request for consultation referral/diagnostic procedure report from Dr. dated 07/07/09

A letter of non-certification, according to an unknown source, from M.D. dated 07/10/09

A non-certification facsimile dated 07/16/09

A letter of non-certification, according to an unknown source, from Williams, M.D. dated 07/22/09

The ODG Guidelines were not provided by the carrier or the URA

## **PATIENT CLINICAL HISTORY**

On 07/03/07, Dr. recommended a lumbar CT scan. An MRI of the lumbar spine on 10/15/07 revealed small disc bulges and a tiny central disc protrusion within the lower lumbar spine. On 10/19/07, Dr. recommended lumbar epidural steroid injections (ESIs), Hydrocodone, Relafen, and Robaxin. A lumbar ESI was performed by Dr. on 11/07/07. On 01/09/08, Dr. recommended physical therapy and continued medications. A lumbar myelogram CT scan on 03/19/08 showed a left foraminal disc protrusion at L4-L5 and vacuum phenomena at L3-L4 and L5-S1. On 04/28/08, Dr. recommended a lumbar discogram CT scan. A lumbosacral CT scan on 04/28/08 showed disc protrusions at L4-L5 and L5-S1. Lumbar spine surgery was performed by Dr. on

07/08/08. An EMG/NCV study on 08/26/08 showed left S1 acute radiculopathy. On 11/24/08, Dr. recommended a Functional Capacity Evaluation (FCE). On 03/27/09, Dr. recommended a lumbar fusion at L4-L5 and L5-S1. An MRI of the lumbar spine on 04/24/09 revealed moderate amounts of enhancing scar tissue at L4-L5 with suggestion of a disc protrusion and a disc bulge at L5-S1 with enhancing scar tissue. On 06/22/09, Dr. recommended a second surgical opinion. On 07/01/09, Dr. recommended an EMG/NCV study and a CT myelogram. On 07/10/09, Dr. wrote a letter of non-certification for a lumbar CT myelogram. On 07/22/09, Dr. also wrote a letter of non-certification for a lumbar myelogram CT scan.

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

The patient underwent a two level (L4-L5 and L5-S1) discectomy by Dr. She has not had any objectively documented clinical improvement despite extensive evaluation and treatment to include physical therapy, medication management, and multiple diagnostic studies and the surgical procedure. A lumbar myelogram with a post myelogram CT scan is not appropriate, according to the evidence based ODG, except for the indications as noted below. The ODG criteria include thoracic spine trauma with equivocal or positive plain films and no neurological deficits, thoracic spine trauma with neurological deficits, lumbar spine trauma with neurological deficits, lumbar spine trauma, seat belt (chance fracture), myelopathy (neurologic deficit related to the spinal cord) traumatic, myelopathy in an infectious disease patient to evaluate pars defect not identified on plain x-rays, and finally to evaluate successful fusion if plain x-rays do not confirm fusion (Lahsonen, 1989). CT myelography is okay if an MRI scan is unavailable or contraindicated (metallic foreign body) or inconclusive. MRIs have largely replaced CT scanning in a non-invasive evaluation of patients with painful myelopathy because of superior soft tissue resolution and multiplanar capability. Invasive evaluation by means of myelography and CT myelography may be supplemented with visualization of normal structures as required for surgical planning or other specific problem solving. The new ACP/APS Guidelines as compared to the old AACPR Guidelines is more forceful about the need to avoid specialized diagnostic imaging such as CT scanning without a clear rationale for doing so. A new meta-analysis of randomized trials find no benefit to routine lumbar imaging (radiography, MRI scan, or CT scan) for low back pain without indications of serious underlying conditions and recommend the clinician should refrain from routine immediate lumbar imaging in these patients. It is clear that the current request does not meet the criteria as outlined by the ODG and therefore, the requested lumbar myelogram with post myelogram CT scan is not reasonable or necessary. It is my opinion that the previous adverse determinations be 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
- X 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
- X 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)
- X OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

ACP/APS Guidelines  
Medical Disability Adviser