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### Notice of Independent Review Decision

**DATE OF REVIEW:** 8/4/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The item in dispute is the prospective medical necessity of a lumbar myelogram with CT.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery and has been practicing for greater than 15 years.

**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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a lumbar myelogram with CT.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:

Md  
Risk Management Fund

These records consist of the following (duplicate records are only listed from one source): Records reviewed from MD: Office notes – 9/11/03-6/15/09, Medical History – 6/15/09, Letter – 12/30/03, 5/11/04, 6/30/04, 8/19/04, & 11/22/04; Ph.D. Psych Eval – 3/19 & 25/09; Hospital Operative Report – 9/14/04, 6/21/05, 2/14/06, 5/25/07, & 7/20/07, Radiology Report – 10/13/03, 6/21/05, & 5/25/07,

Discharge Summary – 12/17/03, MRI report – 7/12/04, MD CT Lumbar Spine report – 6/21/05.

Records reviewed from Risk Management Fund: Pre-authorization denial letter – 2/20/09, 6/25/09, & 6/3/09; MD Pre-authorization request – 5/25/09; R. Hagen fax confirmation – 7/15/09; review results – 5/28/09 & 6/17/09, Care summary – 6/19/09; Hospital History & Physical Exam report – 9/14/04; MD letter – 7/21/09.

A copy of the ODG was not provided for the review by the Carrier or URA.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who was injured on xx/xx/xx when she fell down steps and six weeks later developed back pain. An MRI revealed a herniated disc. She worked until immediately before surgery to perform a laminectomy in 2004 and hasn't worked since. She improved briefly but then her symptoms worsened. Next she underwent fusion nine months later and very slowly recovered. She was unable to walk briefly. She now complains of persistent progressive pain, uses narcotics extensively and has been recommended for a repeat myelogram/CT of her lumbar spine. The neurologic exam has not been noted to have changed since at least 2007. Consideration has been made of trial spinal cord stimulator for chronic pain management and myelogram/CT has been requested prior to implant.

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

According to the ODG, a myelogram is 'Recommended as an option if an MRI is unavailable'. Myelography or CT-myelography should be used for preoperative planning. 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 without a clear rationale for doing so. This patient does not show progressive neurological deficits. The records do not indicate that this patient is in the preoperative planning phase; therefore, the requested service is not medically necessary at this time.

**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)