

# P&S Network, Inc.

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**DATE OF REVIEW:** 2/16/09

**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 Orthopaedic Surgery, 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**

1. Lumbar myelogram followed by CAT scan without contrast
2. CAT scan, lumbar spine, with contrast
3. Myelography lumbosacral-RAS S

## **REVIEW OUTCOME**

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

1. Upheld (Agree)
2. Upheld (Agree)
3. 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 September 1976 Neurology surgery certificate, Dr.
- o February 6, 2008 RME report from Dr.
- o February 6, 2008 MRI lumbar spine read by Dr.
- o March 6, 2008 Medical report from Dr.
- o March 27, 2008 Medical report from Dr.
- o June 19, 2008 Medical report from Dr.
- o September 18, 2008 Medical report from Dr. with recommendation for myelogram
- o September 18, 2008 Lumbar radiographs read by Dr.
- o October 2, 2008 Adverse determination letter for lumbar myelogram with post CT scan
- o October 23, 2008 Medical report from Dr. with request for myelogram, CT scan
- o October 23, 2008 Order for lumbar myelogram with post CT tech. Only from Orthopedic
- o October 30, 2008 Request for procedures from Orthopedics
- o November 20, 2008 Medical report from Dr. with recommendation for myelogram
- o January 7, 2009 Medical report from Dr. with 3rd request for myelogram
- o January 13, 2009 Adverse determination letter for lumbar myelogram with post CT scan.
- o January 22, 2009 Medical report from Dr. with appeal request
- o February 5, 2009 Adverse determination letter for lumbar myelogram with post CT scan.

## PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records submitted for review, the patient is a retired xx-year-old employee who sustained an industrial injury to the low back on xx/xx/xx. He is followed with neurosurgery for continuing low back pain that radiates into the right lower extremity.

Lumbar MRI performed February 6, 2008 shows a mild protrusion/herniation at L1-2 that mildly compresses the thecal sac. Mild narrowing and disc dessication at L2-3. Mild narrowing and disc dessication at L3-4 with mild facet arthrosis on the left more than on the right, producing slight narrowing of the neural foramina and lateral canal on the right. L4-5 and L5-S1 are unremarkable with normal hydration, disc height and facets.

A required medical evaluation was performed on February 6, 2008. The patient slipped in the mud 8 years prior and has been treated since for low back pain. Physical therapy was reportedly not helpful. Medications have been helpful. He is using one Celebrex daily and hydrocodone once weekly. A repeat MRI was performed as he reported subjective weakness in his lower extremities. On examination he has normal muscle tone and bulk without weakness. He has normal sensory function and normal gait. Straight leg raise is negative in the seated position. He can flex to 90 degrees and extend to more than 20 degrees. There is no lumbar spasm on palpation. Reflexes are +1 throughout with exception of trace ankle jerks. He could use a conditioning program. Pain management and epidural injections are not indicated. The MRI should be reviewed. Otherwise he has chronic discomfort but appears to be able to function reasonably well.

The patient was reevaluated by his primary provider on March 6, 2008. The patient reports worsening low back pain that radiates to his right leg described as 8/10 in intensity. He reports subjective weakness in the lower extremity. This is unusual as he has been doing well for the past several years. Nexium is added to his medications. He is 5' 9" and 269 pounds. The neurologic examination is normal. Recommend epidural injection at L1-2 and facet injection at right L3-4.

At reevaluation on March 27, 2008 the patient's flare-up was noted to have resolved a bit. His pain level was 7/10 and it was decided to cut back on medication dosages. The patient's weight states 270 pounds. The diagnosis is herniated lumbar disc with radiculopathy.

The patient was seen again on June 19, 2008. The patient reports worsening low back pain with radiation into the right leg describes as 5/10 in intensity. He reports subjective weakness. He was pleased with the results of an initial lumbar epidural steroid injection (LESI). Request for a second injection was not certified. On examination, lumbar range of motion is restricted. Tiptoe and heel walking are normal. Heel walking reproduces the radicular pain that goes to the back of the thigh bilaterally. He is neurologically intact.

The patient was seen in follow-up on September 18, 2008. He reports chronic aching pain of 6/10. He is unable to ambulate for more than a short distance without developing very severe low back pain and right leg pain that is so severe he would be interested in a surgical solution. His weight states 280 pounds. Recommendation is for lumbar myelogram followed by CT scan. Radiographs are taken and show a few calcifications in the lower aorta and iliac vessels. Normal spinal alignment. Five lumbar vertebrae. Normal calcification. Mild narrowing with degeneration at L3-4, L4-5 and L5-S1. Some facet degeneration is seen at L3-4.

Request for lumbar myelogram followed by CT scan was not certified in review on October 2, 2008 with rationale that the medical records failed to document evidence of radiculopathy per objective physical examination findings. A frank neurocompressive lesion is not documented. Based on the examinations and MRI, the patient is not a surgical candidate. Additionally, RME opinions did not recommend additional diagnostic testing. ODG requirements for another imaging study have not been met. A peer-to-peer discussion was realized without agreement of the provider with the determination.

The patient reports a pain level of 6/10 on October 23, 2008. He has been denied myelogram and CT scan. Despite retirement and decreased physical activity, he has worsening back pain and feels the pain is unbearable. On examination, dorsiflexors and evertors are 4/5 on the right. Deep tendon reflexes are absent. Lumbar flexion elicits radiculopathy into both lower extremities. Straight leg raising reproduces radiculopathy bilaterally, tight more than left. He is using Celebrex, Nexium and Norco. Recommendation was made for in-house myelogram, to be read by the provider.

The patient was seen again on November 20, 2008. The patient reports a pain level of 7/10. He reports numbness and tingling of the left arm of two weeks duration. He reports continuing right leg pain and increase in left leg pain. His health conditions include sleep apnea, high blood pressure and overweight. He smoked two packs daily of cigarettes for 20 years and quit in 1982. He is 284 pounds. Cervical range of motion produces a mild radiculopathic symptoms. Straight leg raise is negative. He needs lumbar myelogram followed by CT.

When reevaluated on January 7, 2009 the patient reported low back pain of 4-5/10 which increases with activities. He has some mild left leg pain as well as his usual right leg pain. His weight is 290 pounds. Right dorsiflexion and eversion strength is 3/5. Lumbar myelogram/CT scan has been denied two times. Request was again made for lumbar myelogram with post CT scan.

Request for lumbar myelogram/CT scan was not certified in review on January 13, 2009 with rationale that the MRI of February 11, 2008 did not show a significant compression of the thecal sac or neural foramen. The February 8, 2008 RME did not identify any significant abnormality neurologically but did report a several month history of lower extremity weakness. A myelogram CT scan is reserved for patients who can not tolerate a MRI or have additional surgical planning needs. At this time the necessity for a surgery of the spine is not validated.

Request for reconsideration for lumbar melogram/CT scan was again not certified in review on February 5, 2009 following a peer-to-peer discussion with the provider with rationale that a specific surgery is not planned at this time. Under current

guidelines myelography can be used only if MRI is not available.

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

Per ODG myelography OK if MRI unavailable. 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. The patient has undergone MRI which shows, mild protrusion/herniation at L1-2 that mildly compresses the thecal sac, mild narrowing and disc dessication at L2-3 and L3-4 with mild facet arthrosis at L3-4 producing slight narrowing of the neural foramina and lateral canal on the right. L4-5 and L5-S1 are unremarkable with normal hydration, disc height and facets. A neurocompressive lesion is not visualized on MRI and, per the provider, a specific surgery is not planned. RME opinions recommended a conditioning program for this patient who is overweight and hypertensive and the results have not been clarified. The patient has some subjective weakness and some weakness on examination, possibly secondary to pain. Electrodiagnostic studies clarifying radiculopathy have not been reported. Myelography cannot be supported at this time. Therefore, my recommendation is to agree with the previous non-certification of the request for lumbar myelography followed by 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
- 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, Lumbar - Myelography 12-20-2008:

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)

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)