URAC ACCREDITED

CLAIMS EVAL

Utilization Review and Peer Review Services

DATE OF REVIEW: 6-4-09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Myelogram with CT scan reconstruction

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

American Board of Neurosurgery

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

4-10-07 EMG/NCS performed by MD.

8-29-07 lumbar CT myelogram.

12-19-08 the claimant underwent a caudal epidural steroid injection.

4-22-09, MD., office visit.

5-5-09, DO., Utilization Review.

5-6-09, MD., letter of appeal.

5-15-09, MD., Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

An EMG/NCS performed by MD., dated 4-10-07 showed right peroneal motor mononeuropathy of unclear etiology. Bilaterally prolonged peroneal F-wave latency.

A lumbar CT myelogram dated 8-29-07 shows bilateral L4 spondylolysis without significant spondylolisthesis. However, there are at least moderate bilateral foraminal stenosis. The degree of the foraminal stenosis would be better ascertained with MRI, which is recommended for correlation. There is mild central canal stenosis at this level. Lumbar myelogram dated 8-29-07 shows spondylotic findings of the lower lumbosacral spine. At L5-S1, there is spondylotic findings with mild bilateral foraminal stenosis.

On 12-19-08, the claimant underwent a caudal epidural steroid injection.

On 4-22-09, the claimant was evaluated by MD. He noted the claimant is a male. On xx-xx-xx he was driving a truck. He injured his low back. He had bowel incontinence. He went to where they did x-rays and injections. He states injection made bit pain worse. He is currently doing therapy. Therapy is helping. He states he has constant low back pain and rates pain at 8/10. He has stabbing pain it his low back. The pain radiates down both legs. He has occasional numbness in his feet. Pain increases with walking. He has some urinary frequency and constipation. He has had lumbar epidural steroid injections, which have not helped. Low back pain is greater than leg pain. Walking increases the leg pain. Has had sexual dysfunction since the injury. On exam, the claimant has low back pain, bilateral leg pain, left worse than right. The claimant has an antalgic gait and uses a cane for ambulation. The claimant has decreased range of motion. SLR on the right is 45 degrees producing low back pain. Motor exam was 4+/5 with left extensor hallucis longus weakness. Sensory exam shows hypoesthesia to pin

over the dorsal aspect of the right foot and lateral aspect of the left foot. Reflexes and 1 and symmetric. The evaluator reported the claimant continues to be symptomatic. He has had conservative therapy over the last two years, but the pain has persisted. The pain remains high rated. He has lumbar epidural steroid injection and physical therapy but has not improved. Therefore, the evaluator recommended lumbar myelogram to look for significant nerve impingement.

On 5-5-09, DO., provided an adverse determination for lumbar myelogram with CT scan reconstruction. Review of records show that the patient had previous MRI last July 2007. Myelogram is indicated if MRI is not available or if it is going to be used for preoperative planning. Dr. states patient has had persistent pain since injury and myelography is for surgical planning. The evaluator reported he requested copies of the electrodiagnostic and MRI, and received instead copy of CT myelogram from 8/29/07. There is not documentation of clinical change since this study, and the evaluator reported he did not receive copies of the MRI or electrodiagnostic reports. Therefore, he could not establish a medical necessity for repeat CT rnyelogram. The evaluator reported that based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request for a lumbar myelogram with CT scan reconstruction is not certified.

On 5-6-09, Dr. provided an appeal letter. The evaluator noted the claimant continues to complain of low back and bilateral leg pain. He has had some bowel incontinence, urinary frequency and constipation. He has been treated conservatively with physical therapy and lumbar epidural steroid injection, which have not helped. The patient also his developed sexual dysfunction since the injury. He has symptoms consistent with neurogenic claudication with increased pain with ambulation. On physical examination, the patient has a positive straight leg raising on the left at 45 degrees, which produced low back and left leg pain. Straight leg raising on the right at 45 degrees produces low back pain. Motor exam reveals evidence of a left L5 radiculopathy with 4+/5 left extensor hallucis longus weakness. There is also hypoesthesia to pin over the dorsal aspect of the right foot and lateral aspect of the left foot. Electrophysiological studies dated 4/10/09 by Dr. revealed findings consistent with radiculopathy. He noted that the MRI scan of the lumbar spine dated 7-14-07 revealed a 3 to 4 mm L4-5 disc protrusion, as well as 3-4 mm L5-S1 disc protrusion. As this patient has not responded to two years worth of conservative treatment, he is being considered for surgery. I have therefore requested a lumbar myelogram for surgical planning. Unfortunately, this was denied. We would like to appeal this denial. The patient has failed conservative therapy. He has very significant symptomatology. He is in need of surgery. Lumbar myelography is indicated as per ODG Guidelines.

On 5-15-09, MD., provided an adverse determination for the requested lumbar myelogram with CT scan reconstruction. The request for lumbar myelogram with CT scan reconstruction is not recommended as medically necessary. This is an appeal of prior denial in which the previous reviewer opined that CT myelogram was not medically necessary, as there were no copies of electrodiagnostic and MRI studies. There was no documentation of clinical change since CT study dated 08/29/07. The evaluator agreed

with previous reviewer as imaging studies and electrodiagnostic studies were not submitted for review. Additionally, no prior CT scans were submitted for review, and there is no additional clinical documentation demonstrating clinical change in the patient, which might suggest changes in the patient's lumbar spine. Only one clinic note was submitted for review reporting evidence of mild motor weakness in the left extensor hallucis longus and hypoesthesia in the right and left foot. There are no additional physical herniations to suggest the recent physical findings are of new or sudden. In the absence of additional clinical documentation and ODG guidelines, medical necessity for the request cannot be established at this time.

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

Medical records reflect the claimant has both radicular pain and axial back pain that has not improved with conservative management since 2007. There is no indication in the records that the claimant has any contraindications to an MRI scan of the lumbar spine. The MRI of the lumbar spine would be very sensitive for the evaluation of degenerative disc disease which is the likely cause of this claimant's axial back pain while a CT myelogram would be sensitive for spinal nerve root impingement which is the likely cause of the claimant 's radicular symptoms. In these more complex patients which continue to have symptoms with EMG/NCV changes, sometimes multi radiographic modalities are necessary to identify the cause of their symptoms. Therefore, the request for a lumbar myelogram with CT scan reconstruction is certified.

ODG-TWC, last update 5-28-09 Occupational Disorders of the Low Back – Lumbar myelogram and CT scan: Recommended as an option. Myelography OK if MRI unavailable. (Bigos, 1999). 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)

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)**