

# US Resolutions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Aug/16/2010

**IRO CASE #:**

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

Lumbar Myelogram with CT

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

MD, Board Certified Neurological Surgeon

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

2010 Official Disability Guidelines, "Low Back" chapter  
, 6/29/10, 7/2/10

M.D. 2/24/94 to 7/26/10

Plain films of the lumbar spine reports 01/15/1997, 01/08/1999, 03/11/2004, 03/28/2005,  
12/7/2009, 06/11/2010

History and physical 01/15/1997, 01/08/1999, 03/24/2004

Operative reports 01/15/1997, 01/08/1999, 03/24/2004

ESI report 06/21/2005

Pathology reports 01/16/1997, 01/08/1999

Discharge summaries 01/15/1997, 01/08/1999

CXR report 01/06/1999

MRI of the lumbar spine reports 02/24/1994, 06/11/2010

CT of the abdomen and pelvis report 06/17/2010

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male with a date of injury xx/xx/xx, when he fell. He then underwent a left L4-L5 laminectomy with excision of herniated disc, and ultimately underwent an L4-L5 interbody fusion. In 1997 he underwent bilateral L3-L4 and L4-L5 decompression with transverse process and lateral facet fusion with bilateral L4-L5 and L3-L4 pedicle screws. In 01/1999 he underwent a bilateral L2-L3 and L3-L4 laminectomy with an L3-L5 posterolateral fusion and an L3-L4 pedicle screws. Since then he has undergone several epidural steroid injections – the last one reported is from 08/2005. On 06/24/2010 he complained of severe lumbar pain with radicular hip and leg pain, particularly on the right with numbness. His examination 12/07/2009 revealed decreased deep tendon reflexes in the lower extremities with weakness in the quadriceps, foot and great toe dorsiflexion and plantar flexion. An MRI of the lumbar spine 06/11/2010 revealed a 7mm retrolisthesis of L2 on L3 with moderate central stenosis and severe right and moderate-to-severe left neuroforaminal stenosis. There are severe degenerative findings at this level. At L3-L4 there is mild central stenosis with moderate bilateral neuroforaminal stenosis, most severe on the right. At L4-L5 there is mild

central with moderate to severe bilateral foraminal stenosis, worse on the left. At L5-S1 there is mild left and moderate right neuroforaminal stenosis. Other abnormalities were also seen, which prompted performance of a CT of the abdomen and pelvis. This showed a soft tissue mass anterior to the inferior vena cava and abdominal aorta. No evidence of GI consult or endoscopy was presented in the records. There is also a possible left adrenal adenoma and fatty infiltration of the liver.

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

The lumbar myelogram with CT is not medically necessary. According to the ODG, "Low Back" chapter a myelogram is indicated if the MRI is inconclusive, unavailable or contraindicated. There is no indication that it is any of these. The findings on examination as well as the patient complaints correlate with the findings on MRI.

Also, the ODG states that a CT myelogram may be done for preoperative planning and problem solving. It is not stated that the provider is planning on surgery. There are no conservative measures mentioned since 2005, and there are other medical issues, which are presently being worked up. Therefore, based on the submitted documentation the reviewer finds that there is no medical necessity for Lumbar Myelogram with CT at this time.

2010 Official Disability Guidelines, "Low Back" chapter

Myelography/CT 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)

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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)