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Notice of Independent Review Decision

DATE OF REVIEW: 12/29/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

CT Myelogram, Flexion and Extension, Lumbar Spine

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

Certified by the American Board of Physical Medicine & Rehabilitation

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective			Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Letters dated 12/14/09, 11/19/09

Medical notes dated 6/4/09, 6/24/09, 6/29/09, 8/28/09, 10/12/09, 10/26/09, 11/18/09

Physical Assessment Evaluation and Treatment Plan dated 9/15/09

X-ray report dated 6/4/09

Official Disability Guidelines cited-Low Back, Lumbar and Thoracic Chapter-
 CT & CT Myelography (computed tomography)

PATIENT CLINICAL HISTORY:

This patient slipped and fell on xx/xx/xx. The patient complains of upper and lower back pain radiating into the bilateral lower extremities.

MRI lumbar spine performed 06/04/09 revealed mild disc bulge at L3-4 which mildly impinges upon the thecal sac, with a mild degree of degenerative facet and ligamentum flavum hypertrophy at this segment. Moderate sized broad based right paracentral disc protrusion was seen at L4-5 which moderately effaces the thecal sac and also severely narrows both of the

lateral recesses. A mild degree of degenerative facet and ligamentum flavum hypertrophy is noted at this level as well. A mild posterior central disc protrusion is noted at L5-S1 with mild degenerative facet joint hypertrophy. There are multiple small annular tears in the anterior posterior fibers of the intervertebral discs at L3-4 and L4-5. Electrodiagnostic testing performed 06/11/09 was reported as normal.

Records indicate the patient was treated conservatively with physical therapy and epidural steroid injections without significant improvement. Physical examination findings reported the patient to be 5'7" tall and weigh 227 pounds. Lumbar spine examination reported paraspinal spasm present L1-L5. There was tenderness to palpation on L1-L5 paraspinals and SI joint. Straight leg raise was positive in supine 0-70 on the right and cross to straight leg raise positive. Patrick's was negative. Neurologic examination reported cranial nerves II-XII intact. Muscle strength was 5/5 throughout the bilateral upper and lower extremities. Grip strength is normal. There was decreased sensation to light touch in the left upper extremity. DTRs were 2+ throughout the bilateral upper and lower extremities.

The patient was seen on 10/26/09. The patient was recommended to continue epidural steroid therapy, and to undergo CT myelogram of the lumbar spine to better evaluate internal disc disruption and foraminal stenosis at L4-5 for surgical planning.

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

In the Reviewer's opinion, medical necessity is not established for the proposed CT myelogram, flexion and extension, lumbar spine. The Reviewer noted that MRI of the lumbar spine has appropriately identified the relevant pathology with no evidence of artifact or inconclusive findings. Moreover, electrodiagnostic testing revealed no evidence of radiculopathy. On multiple examinations, the patient had no evidence of motor deficit, with sensory deficit noted to light touch on the left upper extremity. Given the current clinical data, the requested procedure is not supported as medically necessary.

REFERENCES:

2009 Official Disability Guidelines, 15th Edition, Work Loss Data Institute, Online Edition, Low Back Chapter.

CT & CT Myelography (computed tomography)

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)

