Advanced Medical Reviews

ACCREDITED EXTERNAL REVIEW

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 6/8/2010
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Myelography, lumbosacral, radiological supervision and interpretation

QUALIFICATIONS OF THE REVIEWER:
Orthopaedics, Surgery Spine, Neurosurgery

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

X Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)

Myelography, lumbosacral, radiological supervision and interpretation Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Fax page by author unknown dated 5/20/2010
2. Letter by, dated 5/20/2010
3. Review organization by dated 5/19/2010
4. Request for a review by author unknown dated 5/19/2010
5. Appeal prospective by, MD dated 5/18/2010
6. Letter by, dated 5/17/2010
7. Request form by author unknown dated 5/14/2010
8. Fax page by author unknown dated 5/14/2010
9. Letter by, dated 4/27/2010 & 5/18/2010
10. Initial prospective by , DO dated 4/26/2010
11. Clinical note by author unknown dated 4/22/2010
12. Request for authorization by author unknown dated 4/22/2010
13. Clinic notes by author unknown dated 4/16/2010
14. Letter by, dated 3/3/2010
15. Radiology report by, MD dated 2/25/2010
16. Progress notes by author unknown dated 2/22/2010 to 5/11/2010
17. Note by author unknown dated 1/29/2010
18. Re-examination by, MD dated 1/20/2010
19. Status report by author unknown dated 1/20/2010
20. History note by, MD dated 1/20/2010
21. Clinical note by author unknown dated 1/17/2010
22. Workers compensation by author unknown dated 1/4/2010
23. Medical evaluation by author unknown dated unknown
24. Official Disability Guidelines (ODG)

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:
The injured employee is a male whose date of injury is xx/xx/xx. Records indicate the injured employee stepped out of a van and felt sudden pop in his back and began having excruciating pain in the back which subsequently radiated into the right lower extremity. Records indicate the injured employee has had previous imaging / diagnostic studies including lumbar spine MRI, lumbar discogram, and EMG/NCV. Imaging studies revealed degenerative disc disease at L4-5. Discogram was noted as positive for severe constant pain at L4-5 and moderately severe concordant pain at L5-S1. The injured employee underwent designated doctor examination on 01/20/10 and was found to not

have reached maximum medical improvement. The designated doctor recommended EMG/NCV which was performed on 01/20/10 and revealed bilateral L4-5 lumbar radiculopathy with loss of right L5 peroneal F wave response.

A request for CT myelogram was reviewed on 04/26/10 and recommended as not medically necessary. The reviewer determined the injured employee has had MRI, EMG/NCV and discogram which all indicate L4 and L5 pathology. Discogram was noted with finding that indicated most severe concordant pain at L4-5, and there was no need to obtain another diagnostic test. It was also noted there was no indication the injured employee had any new neurologic findings to warrant further workup.

An appeal request for CT myelogram of the lumbar spine was reviewed on 05/18/10 and determined as not medically necessary. Reviewer noted that clinical documentation indicated the injured employee previously underwent lumbar discogram on 10/01/09 with evidence of concordant pain at L4-5 and L5-S1. The injured employee also underwent electrodiagnostic study on 01/22/10 with evidence consistent with bilateral L4-5 radiculopathy. In addition, the injured employee underwent MRI study of the lumbar spine on 02/25/10 with evidence of 4 mm disc protrusion and slight impression on anterior thecal sac at L4-5 level. The reviewer noted that most recent legible comprehensive physical examination failed to document any objective clinical findings of neurologic deficits. The reviewer indicated the injured employee has undergone sufficient diagnostic procedures that would explain objective findings.

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

The clinical data submitted for review does not establish medical necessity for the proposed lumbar myelogram with post CT scan. The injured employee sustained an injury to low back in xx/xx. Imaging studies revealed evidence of lumbar disc pathology at L4-5 level. The injured employee was treated conservatively with medications, physical therapy, and epidural steroid injections without significant improvement. Physical examination was noted to reveal no focal weakness, sensation was intact, and reflexes were normal. The injured employee underwent lumbar discogram that revealed evidence of concordant pain at L4-5 and L5-S1. EMG/NCV performed 01/20/10 reported findings consistent with bilateral L4-5 radiculopathy. Noting the injured employee has undergone extensive workup of the lumbar spine with MRI scans, lumbar discogram and electrodiagnostic studies, the relevant pathology has been appropriately identified. As such, there is no medical necessity for CT myelogram of the lumbar spine. The recommendation is to uphold the previous denial.

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
- **X** 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)