

# Core 400 LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jun/23/2010

**IRO CASE #:**

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

Outpatient lumbar CT/myelogram with standing flexion and extension

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** MD, Board Certified Neurosurgeon

**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**

5/12/10, 5/20/10

M.D. 5/13/10, 3/8/10, 8/19/09

M.D. 12/16/09

Clinic 10/1/09, 6/3/10, 5/6/10, 4/5/10, 4/2/10, 3/27/10, 3/22/10, 2/8/10, 8/24/09

M.D. 5/7/09

Rehab 09/25/2009, 9/30/09

New patient questionnaire 8/24/09

Dr. 12/16/2009

2010 Official Disability Guidelines, 15th edition

**PATIENT CLINICAL HISTORY SUMMARY**

This is a female with a date of injury xx/xx/xxxx, when she slipped and fell on a wet floor, landing on her bottom and over on her right side. Plain films were taken at the time of the lumbar, which were unremarkable, except for mild degenerative changes. She has had treatment to her right shoulder and knee. She complains of back pain with radiation down the legs and numbness/tingling to the right foot. She has morbid obesity with a BMI of 52.9. On examination she has slight bilateral gastrocnemius muscle weakness. L4 and S1 reflexes are depressed. Also, there are sensory defects to the right foot. In 02/2010 there were sensory deficits noted on the left foot. She has undergone physical therapy and an epidural steroid injection on 03/27/2010, which gave pain relief for only 2-3 days. An MRI of the lumbar spine 07/17/2009 demonstrated foraminal protrusion on the right at L3-L4. There is minimal disc dessication at L4-L5. At L5-S1 there is a 3mm broad-based annular bulge extending into the neuroforamina on both the right and left with mild foraminal narrowing to the right (official report not submitted for review). The provider is recommending an outpatient lumbar CT/myelogram with standing flexion and extension.

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

The myelogram with CT is not medically necessary. According to the Official and Disability Guidelines, a CT myelogram is indicated if an MRI is contraindicated, inconclusive, or unavailable. It can also be used for surgical planning. It is not evident that the MRI is inconclusive. Her neurological examination shows little objective evidence of radiculopathy, and any findings on examination can be correlated with the MRI. The findings of neuroforaminal narrowing on MRI are "mild" and no EMG has been submitted for review.

A CT myelogram might be helpful if clinical findings do not correlate with neuroimaging. However, again, there is no significant objective evidence of radiculopathy to support the medical necessity of a CT myelogram. Also, it does not appear that the claimant is a surgical candidate. For these reasons, the reviewer finds that CT myelogram is not medically necessary.

**Myelogram/CT**

Not recommended except for surgical planning. Myelography or CT-myelography may be useful for preoperative planning. (Bigos, 1999) (Colorado, 2001)

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)