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Notice of Independent Review Decision

Amended September 10th, 2010

DATE OF REVIEW: 09/07/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Myelogram with Post CT Scan

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

This case was reviewed by a Texas licensed MD, specializing in Orthopedic Surgery. The physician advisor has the following additional qualifications, if applicable:

ABMS Orthopaedic Surgery
 ABMS Orthopaedic Surgery

REVIEW OUTCOME:

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

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Lumbar Myelogram with Post CT Scan	62284	-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	IRO Request		16		
2	Designated Doctor Report	MD	16	03/31/2010	03/31/2010
3	Diagnostic Test	Imaging	2	10/08/2009	10/08/2009
4	Diagnostic Test	Medical Center	3	10/27/2008	10/28/2008
5	Diagnostic Test		1	12/15/2009	12/15/2009
6	Diagnostic Test	Diagnostic	2	11/05/2009	11/05/2009
7	Diagnostic Test	Imaging and Diagnostic	2	03/07/2006	03/07/2006
8	Diagnostic Test	DO	2	09/30/2009	09/30/2009
9	IRO Request	TDI-DWC	14	08/17/2010	08/18/2010
10	Office Visit Report	MD PhD PA	4	03/01/2010	03/01/2010
11	Office Visit Report		20	03/15/2006	07/16/2010
12	PT Notes	Occupational and Physical Therapy	1	06/23/2010	06/23/2010
13	Initial Denial Letter		16	07/22/2010	08/02/2010
14	Archive		83	08/27/2010	08/27/2010
15	Archive		76	10/22/2008	08/18/2010
16	IRO Decision		6		
17	IRO Decision		6		
18	Invoice		1		

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is with a DOI of xx/xx/xx. He fell from the belly of an aircraft suffering injury to cervical spine, both shoulders, right elbow and right hand. He has a past history of diffuse multilevel spinal degenerative disc disease. He has a past history of injury 06/2003 and he underwent a lumbar surgery in 9/2003. He has undergone yet another lumbar surgery on 10/28/08. He has had persistent low back pain and leg pain, left greater than right. He has demonstrated straight leg raising positive bilaterally. He suffers chronic low back

pain with leg pain in spite of the two lumbar spinal surgeries that have already been performed. A request was submitted for preauthorization of lumbar myelogram with CT myelogram. The request was considered and denied; it was reconsidered and denied. This is the IRO request for medical necessity for a CT myelogram.

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

1. Is the performance of lumbar myelogram medically necessary and appropriate? No. It does not appear that lumbar myelogram is medically necessary or appropriate at this time. High quality MRI scan is available. CT myelogram is unnecessary and criteria for the performance of such have not been met. The applicable passage from the ODG, 2010, low back chapter is cited above. The physical findings documented in the medical records submitted with this request do not include any suggesting progression or change in neurological findings. It would appear that this patient is suffering failed back syndrome. Chronic pain consultation has not been obtained. This request is not medically necessary. The prior denials were appropriate and should be upheld.

CT & CT Myelography (computed tomography):

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)