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**Notice of Independent Review Decision
Reviewer's Report**

DATE OF REVIEW: September 8, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

CT scan of the lumbar spine and myelogram.

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

M.D., Board Certified in Orthopedic Surgery.

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)

Although CT scan of the lumbar spine is medically necessary, myelogram is not medically necessary. Therefore, the Carrier's denial of the requested services should be partially overturned.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 8/10/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 8/17/10.
3. TDI Notice to IRO of Case Assignment dated 8/19/10.
4. Medical records from dated 5/20/10, 6/24/10, 7/22/10, and 8/5/10.
5. Letter from, MD dated 6/30/10.
6. Denial documentation dated 6/8/10 and 7/14/10.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male with a history of an electrocution injury on xx/xx/xx with subsequent pain in his neck and upper and lower back. The patient had an L3 to sacrum posterior fusion. According to his history, he was improved for approximately six months following surgery but then had gradually recurring pain in the lower back and legs. The patient began treating with a spine surgeon on 5/20/10. The patient also complained of worsening pain in his upper back at the thoracolumbar junction and upper thoracic spine. Pain radiated down the legs to the bottom of the right foot as well as the left posterior thigh with numbness. The physician requested a CT scan of the lumbar spine with myelogram.

The physician saw the patient in follow-up on 6/24/10. He stated that the diagnosis was flat back deformity, possible pseudoarthrosis, and possible symptomatic hardware with bilateral L5 radicular pain. He noted that at the previous visit, he recommended a CT scan to evaluate the fusion for healing. He indicated that although the patient did not have any neurological changes, the request was to evaluate the arthrodesis as plain x-rays alone were not adequate. In addition, he noted that should the patient require

an osteotomy to address his flat back deformity, myelogram with a CT scan would be useful for surgical planning.

A pre-authorization determination dated 7/14/10 denied the requested CT scan. A letter from the patient's physician states that the previous CT scans were from 1997 and 1999 and those films were not available. The report from 1999 suggested there was a solid fusion and the report from 1997 showed incomplete fusion. The physician also noted that the patient clearly did not have a normal lordosis and he requested a CT scan with myelogram to assess the patient's fusion. The Carrier has denied this request citing a lack of medical necessity.

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

This case involves a request for a lumbar CT scan and a myelogram. According to Official Disability Guidelines, a lumbar myelogram is indicated if there is any change in a patient's neurologic examination which would be concerning for radiculopathy. In this patient's case, the records indicate there have not been any neurological changes. As such, the patient does not meet accepted guidelines for a myelogram. However, as the patient's physician indicates, there is concern for possible pseudoarthrosis in this setting. Although a myelogram is not indicated to assess for pseudoarthrosis or flat back deformity, a CT scan is clinically useful in this setting. The proposed CT scan will allow assessment of the fusion for healing. CT is more accurate in this setting than x-ray. All told, a lumbar spine CT scan is medically necessary to assess this patient's ongoing low back and leg pain post L3-S1 fusion.

In conclusion, I have determined that although the requested myelogram is not medically necessary for treatment of the patient's medical condition, the requested CT scan is medically necessary. Accordingly, the Carrier's denial should be partially overturned.

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)