

SENT VIA EMAIL OR FAX ON  
Apr/04/2011

## Independent Resolutions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Apr/04/2011

**IRO CASE #:**

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

CT Myelogram of the lumbar spine and X-rays of the lumbar spine

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

Board Certified Orthopedic Surgeon

**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**

OD Guidelines

1. Letter of medical necessity D.C. 01/25/11
2. Reconsideration / appeal determination 02/01/11 regarding non-certification CT myelogram of lumbar spine and plain films
3. Initial utilization review determination 01/20/11 regarding non-certification CT myelogram of lumbar spine and plain films
4. Office notes M.D. 11/05/10 and 12/28/10

**PATIENT CLINICAL HISTORY SUMMARY**

The injured employee is a female who reportedly was injured on xx/xx/xx while restraining a patient in a . She complains of pain in lower lumbar region. X-rays of lumbar spine performed on 01/26/10 were noted to show degenerative disc space at L5-S1. MRI of lumbar spine was performed on xx/xx/xx and was noted to show left sided HNP L5-S1. Electrodiagnostic testing performed on 08/19/10 of bilateral lower extremities was noted to reveal evidence of bilateral L5-S1 radiculopathy. Physical examination on 11/05/10 reported the injured employee to be 5 feet tall and 273 lbs. Musculoskeletal exam reported gait intact; station, posture normal; and Romberg negative. Head and neck were normal to inspection and palpation with full and painless range of motion of neck. There was normal strength and tone. There was tenderness over the lower lumbar spine. Motor strength was 5/5 throughout except left gastrocnemius complex 4/5. Neurologic evaluation reported deep tendon reflexes

2+/4+ at bilateral knees and ankles. Sensation is decreased in left S1 dermatome. Straight leg raise is negative bilaterally. The injured employee underwent lumbar epidural steroid injection and only got about 30% relief of symptoms for 3-4 days. The injured employee was recommended to undergo CT myelogram of lumbar spine.

A request for CT myelogram lumbar spine with x-rays of lumbar spine was reviewed by Dr. on 01/20/11. Dr. determined the request was non-certified as medically necessary. Dr. noted that ODG criteria for CT myelogram includes neurologic deficit and lumbar spine trauma, myelopathy findings that are not present to evaluate pars defect which plain films have not noted, and evaluate successful fusion. The patient has not had fusion surgery. Dr. further noted that the rationale for recommending non-certification for x-ray of lumbar spine is that prior x-rays performed of lumbar spine should be sufficient as there has not been interval incident that would necessitate repeat plain x-rays. Dr. noted this was in line with ODG for plain x-rays for uncomplicated low back pain with trauma, steroids and osteoporosis or over 70, and the patient has had one series and no indication of new trauma.

A reconsideration / appeal request was reviewed by Dr. on 02/01/11, and Dr. determined the request as non-certified. Dr. noted the clinical documentation provided for review does not support the request for CT myelogram or plain films of lumbar spine as there was no indication from the clinic note that the patient has sustained any significant trauma to lumbar spine, and prior MRI studies revealed minimal findings at L5-S1. Dr. further noted that the patient does not exhibit any focal neurologic deficits on exam, and there is no indication the patient's physical examination has significantly changed that would require repeat imaging studies. Dr. noted the clinic notes suggest the patient may be surgical candidate; however, due to lack of any neurologic deficits on physical examination, evaluation by CT or plain films would not be warranted at this point in time.

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

The clinical data presented does not support a determination of medical necessity for CT myelogram of lumbar spine and x-rays of lumbar spine. The injured employee is noted to have sustained injury to low back on xx/xx/xx. She has undergone workup with MRI of lumbar spine on xx/xx/xx as well as plain radiographs on 01/26/10 and electrodiagnostic testing on 08/19/10. All of these studies revealed findings related to L5-S1 level. The injured employee has not evidence of progression of neurologic deficit on clinical examination. There is no indication that the injured employee has shown any significant change in clinical presentation that would necessitate repeat studies of the lumbar spine. Official Disability Guidelines Low Back Chapter notes that CT myelogram may be okay if MRI is unavailable, contraindicated or inconclusive. There is no evidence that the injured employee meets any of these criteria. Accordingly the request for CT myelogram of the lumbar spine and for plain x-rays of the lumbar spine is not indicated as medically necessary.

#### **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)