

SENT VIA EMAIL OR FAX ON  
Dec/12/2011

## True Decisions Inc.

An Independent Review Organization  
2002 Guadalupe St, Ste A PMB 315  
Austin, TX 78705  
Phone: (512) 879-6332  
Fax: (214) 594-8608  
Email: rm@truedecisions.com

### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**  
Dec/09/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Outpatient Lumbar Myelogram with CT

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

**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  
Utilization review 10/25/11  
Utilization review 11/03/11  
Office notes Dr. 10/13/11  
MRI lumbar spine 01/17/11, 05/17/06, 04/27/06, and 11/11/05  
EMG/NCV 05/09/06  
Insurance Response regarding disputed services 12/01/11  
Operative report right L5-S1 microdiscectomy 03/03/06  
Clinic Physician Record 02/28/06-11/01/11  
Designated doctor evaluation 09/08/06  
Office notes Dr. 02/15/11  
Office notes Dr. 03/01/11

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who injured his low back on xx/xx/xx when he was picking up an 85 lb tire. After failing conservative treatment, the claimant underwent L5-S1 microdiscectomy on 03/03/06. Records indicate the claimant obtained little benefit from surgery. He continues to complain of low back pain and right leg pain. MRI of lumbar spine on 01/17/11 revealed postoperative changes of right hemilaminectomy at L5-S1. There is a disc bulge with small right sided disc herniation and mild facet hypertrophy causing mild molding of sac and right foraminal encroachment. There is stenosis of right lateral recess of S1 which could be due to disc material or epidural fibrosis. At L4-5 there is a small midline disc herniation slightly impressing the thecal sac. The remainder of the exam is unremarkable. The claimant was seen by Dr. on 10/13/11 with increasingly severe mechanical lumbosacral pain exacerbated by walking, standing and activities, with radicular pain down the right leg into calf and then into the foot. It is noted the claimant has had physical therapy. Medications included Hydrocodone, Flexeril, Cymbalta and Neurontin. On examination the claimant is noted to be 5'8" tall and 195 lbs. He has well healed lumbar incision. There is loss of lumbar lordosis. He walks with flexed posture of low back. He has a right antalgic gait. There is tenderness over the right sciatic outlet. Flexion of low back reproduces pain down the right leg. Straight leg raise on left side is 60 degrees, refers pain to right hip and leg. Straight leg raise is positive on right at less than 45 degrees. Deep tendon reflexes are 2+ in knees and left ankle and 1+ in right ankle. There is no focal muscle atrophy or fasciculations, no pathologic reflexes were identified. There is decreased sensation of the distal right S1 dermatome including posterolateral calf and lateral foot. There is some weakness with plantar flexion over right foot and great toe. Lumbar myelography with post Myelographic CT scanning was recommended.

A utilization review performed on 10/25/11 recommended non-certification of request for lumbar myelogram with CT. It was noted the claimant presently complains of low back pain radiating to right lower extremity with associated numbness, dysesthesias, and weakness exacerbated by walking, standing, and activity. Physical examination dated 10/13/11 revealed loss of lumbar lordosis with flexed posture and right antalgic gait. There is tenderness over the right sciatic outlet with limited range of motion associated with pain. Straight leg raise is positive bilaterally, and deep tendon reflexes decreased on right. There is likewise decreased sensation in distal right S1 dermatome including posterior calf and lateral foot as well as some weakness of plantar flexion of right foot and great toe. It was noted there was no indication the MRI done on 01/17/11 was inconclusive or there was need for any further investigation. Surgical procedure being contemplated and how this invasive test will change treatment recommendation was not documented. There is no objective documentation that the claimant has failed conservative treatment to warrant further investigation of signs and symptoms. It was noted the claimant has previous physical therapy visits. There were no submitted physical therapy reports or recent physical therapy evaluation to validate the total number of visits completed as well as to demonstrate lack of functional improvement and / or pain relief. Maximized pharmacotherapy was likewise not substantiated with objective pain assessment utilizing VAS scores and symptom log in response to medication use. Medical necessity of the request cannot be established.

An appeal request for outpatient lumbar myelogram with CT was reviewed on 11/03/11, and the request was non-certified as medically necessary. It was noted the claimant's complaints included lumbosacral and right leg pain with numbness, dysesthesia and weakness in right leg with minimal left lower extremity symptoms. Physical examination findings included rightward antalgic gait, tenderness to palpation over the right sciatic outlet, positive right straight leg raise, right foot and great toe plantar flexion weakness, without muscle atrophy weakness or fasciculations, decreased sensation in right S1 dermatomal pattern and no abnormal reflexes. The claimant was noted to have recurrent right sided L5-S1 disc extrusion with significant right S1 radiculopathy. The requested imaging was ordered for "further investigation and preoperative planning." A diagnosis had already been specified. Lumbar MRI was conducted less than 1 year ago, and it is unclear what further investigation is needed. The plan / contemplated procedure have not been specified, and there is no clear indication the claimant wishes to proceed with surgery. If updated imaging is needed in advance of surgery, it is unclear why the requested technique involving invasive procedure and potential associated complications is necessary as opposed to other imaging which is not

contraindicated, does not involve invasive procedure, and is noted by cited criteria to be better study in patients who have previously undergone lumbar surgery.

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

Medical necessity is not established for outpatient lumbar myelogram with CT based on clinical data provided for review. The claimant is noted to have sustained lifting injury to low back on xx/xx/xx. He underwent right L5-S1 microdiscectomy on 03/03/06, but remains symptomatic following surgery. Records indicate his condition was refractory to conservative treatment including physical therapy and medications. MRI of lumbar spine performed on 01/17/11 revealed postoperative changes at L5-S1, with disc bulge, small right sided disc herniation, and mild facet hypertrophy causing mild molding of sac and right foraminal encroachment. Stenosis of right lateral recess of S1 was noted which could be due to disc material or epidural fibrosis. Office note dated 02/15/11 indicated the claimant would likely benefit from transforaminal epidural steroid injection, but there is no documentation this was performed and results thereafter. Per ODG guidelines, CT myelogram may be indicated if MRI is unavailable, inconclusive, or contraindicated. The claimant in this case does not meet any of the criteria specified; therefore, the proposed lumbar myelogram with post CT is not indicated as medically necessary. The previous denials were correctly determined and should be upheld on IRO.

**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)