INDEPENDENT REVIEWERS OF TEXAS, INC.

4100 West El Dorado Pkwy · Suite 100 – 373 · McKinney, Texas 75070
Office 469-218-1010 · Toll Free 1-877-861-1442 · Fax 469-218-1030
e-mail: independentreviewers@hotmail.com

Notice of Independent Review Decision

DATE OF REVIEW: 12/30/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Appeal Lumbar CT Myelogram
Request Received Date 12/03/2010

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

Texas Board Certified Neurosurgeon
Fellowship Trained in Spine Surgery

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male with a history of low back pain.

Radiographs of the lumbar spine performed 06/12/98 are negative with no evidence of fracture or subluxations.

The employee saw Dr. on 07/27/98. The employee complained of pain in the lumbar area to the left of midline with extension into the left buttock and into the cervical area. The employee reports frequent muscle spasms in this region. Physical examination revealed pain range of motion of the neck. There was limited lumbar range

of motion. Straight leg raise was negative bilaterally. The employee was recommended for radiographs of the cervical spine and MRI of the cervical and lumbar spine.

Radiographs of the cervical spine performed 08/03/98 were normal. MRI of the cervical spine performed 08/03/98 was normal. MRI of the lumbar spine performed 08/03/98 demonstrated desiccation of the L5-S1 discs with minimal posterior disc bulge, slightly to the left of midline with slight displacement of the S1 nerve root. No nerve root impingement was seen.

MRI of the lumbar spine performed 04/23/02 demonstrated a small left paracentral disc herniation at L5-S1 with partial compromise of the left lateral recess. No other significant abnormalities were identified.

Radiographs of the cervical and lumbar spine performed 04/24/02 were normal.

The employee was discharged from physical therapy on 06/04/02 after attending one session due to noncompliance.

MRI of the lumbar spine performed 12/10/02 demonstrated an annular tear and left paracentral disc protrusion at L5-S1 contacting the nerve root, enlarged from 08/03/98.

The employee saw Dr. on 12/11/02 with complaints of severe lumbar pain with some sciatic radiation to both lower extremities. Physical examination revealed decreased ankle jerks bilaterally. Straight leg raise was positive bilaterally. The employee was assessed with L5-S1 disc protrusion. The employee was recommended for surgical intervention.

The employee underwent bilateral discectomy, facetectomy, and foraminotomy at L5-S1, posterior lumbar interbody fusion at L5-S1, posterolateral mass fusion of L5-S1, segmental instrumentation of the spine at L5-S1, harvest of bone for fusion, and insertion of bone growth stimulator on 12/26/02.

The employee saw Dr. on 06/25/03. The employee was able to walk on his toes and heels. Straight leg raise was negative. There was discomfort with lumbar range of motion. The employee complained of pain over the posterior right iliac crest area. The employee was advised to follow-up in one month.

The employee saw Dr. on 07/08/10 with complaints of low back pain rating 9 out of 10. The pain started after he bent over a box while. Physical examination revealed the employee was able to forward bend to 20 degrees. Straight leg raise was negative. The deep tendon reflexes were symmetrical. The employee stated the inserted bone stimulator no longer functioned because the battery went down. The

employee was assessed with low back pain. The employee was prescribed Mobic and Toradol.

Radiographs of the lumbar spine performed 07/08/10 demonstrated postoperative changes at L5-S2 with no evidence of fracture or obvious focal malalignment.

CT of the lumbar spine performed 07/16/10 demonstrated degenerative disc disease at L5-S1 and L4-L5. There was some mild disc bulging seen. There was no caudal sac compression or nerve root region compression identified. There was no fracture or dislocation seen. There was no acute bony abnormality. A stimulator overlies the dorsal aspect of the lumbar spine.

The employee saw Dr. on 08/03/10 with complaints of chronic low back pain that extended into the shoulder blades. The employee rated the pain at 4 to 5 out of 10 on the visual analog scale. The employee denied bowel or bladder dysfunction. Physical examination revealed full strength throughout the upper and lower extremities. Sensation was grossly intact to light touch. Straight leg raise elicited back pain only. Lumbar range of motion was limited due to pain. The employee was recommended for a lumbar epidural steroid injection.

The employee saw Dr. on 11/19/10 with complaints of chronic low back pain that extended into the shoulder blades. Physical and neurological examinations were noted to be unchanged. The employee was recommended for a lumbar myelogram with post myelogram CT to better evaluate his condition.

The request for lumbar myelogram CT Scan was denied by utilization review on 11/30/10 due to lack of documentation as to whether an MRI was available to this employee or was contraindicated. The employee's functional deficits did not warrant going outside guideline recommendations.

The request for lumbar myelogram CT Scan was denied by utilization review on 12/10/10 due to lack of documentation of neurosensory or motor deficits. There was no documentation of a contemplated surgery or other intervention which would require further investigation with the proposed CT myelogram. There was no satisfactory evidence in the records that this employee had maximized benefits from adequate conservative management consisting of optimized pharmacotherapy, activity modification, physical therapy, and injections. The proposed study was deemed inconsistent with clinical review criteria.

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

The requested lumbar CT/myelogram is not recommended as medically necessary for this employee. The employee has chronic axial back pain radiating to the shoulders. There is no evidence of recent neurologic changes or unexplained deficits that would indicate any changes in lumbar pathology. The employee has undergone lumbar surgery and has a spinal cord stimulator placed and there is no evidence to suggest any hardware failure that would require further evaluation with CT myelogram studies. The employee also does not appear to be a surgical candidate at this time.

Without evidence of any progressive or severe neurologic deficits, or without initial plain film evidence of possible hardware failure, medical necessity for the request is not supported.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

Official Disability Guidelines, Online Version, Low Back Chapter.