

# The DYLL REVIEW

We take the worry out of Peer Reviews

25 Highland Park Village #100-177 Dallas TX 75205

Phone: 888-950-4333 Fax: 888-9504-443

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## Notice of Independent Review Decision

**DATE OF REVIEW: 06/15/2011**

**IRO CASE #:**

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

CT / myelogram, lumbar spine.

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

The physician performing this review is Board Certified, American Board of Orthopedic Surgery. He has been in practice since 1982 and is licensed in Texas, Oklahoma, Tennessee and California.

**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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The adverse determination by both reviewers for the myelogram/CT is appropriate, and the adverse decision is upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records Received: 17 page fax 5/26/11 Texas Department of Insurance IRO request, 78 page fax 5/26/11 URA response to disputed services including administrative and medical records, 24 page fax 5/26/11 Provider response to disputed services including administrative and medical records.

The information provided includes request information for review two peer reviews 05/09/11 and 05/16/11 with 05/04/11 report by Ph.D., and follow-up reports from M.D., 05/03/11, and 01/04/11 and 11/03/10 with imaging reports and electrodiagnostic studies 07/23/09 by Dr., an MRI with CT of the lumbar spine, 10/13/09, comparing to a previous 09/26/06. The percutaneous placement of electronic quad leads introduced at T12-L1 advanced to T8 and T9 under fluoroscopic control, 03/06/07

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This female was originally injured xx/xx/xx when she tripped and fell. Subsequently, the patient has undergone six lumbar spine surgeries with the patient having L3 through S1 laminectomies and fusions. The patient now has

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been noted to have an L2-3 retrolisthesis with disk space height loss, endplate sclerosis, and irregularity noted. The patient has been treated long term by Dr. for the chronic, intractable low back pain with OxyContin being prescribed and with the spinal cord stimulator having been performed. Dr. on 05/03/11 noted the patient had no significant change in history, medication, allergies, or surgical history since previously with continued pain medications utilized to control the pain so the patient can do activities of daily living. The patient indicated doing anything wrong with her neck causes her to pay for three or four days of increase in pain. Objectively, the patient has positive seated root test, weakness left lower extremity, with diagnosis of chronic, intractable low back and leg pain with failed back surgery syndrome with L2-3 instability.

The request for L2-3 surgery was recently denied, and a CT/myelogram has been requested. Both prior peer reviews noted there was lack of documentation of progressive neurological deficit and/or any indication that there is a concern for pseudoarthrosis of the prior fusion levels, and the recommendation was for non-certification of the requested CT/myelogram

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

At this time, I agree with the prior peer reviews. The medical records do not document a progressive neurological deficit, nor is there an indication as to concern for pseudoarthrosis, which would be the indication accepted by ODG for CT/myelogram. Therefore, in line with ODG guidelines for CT/myelography, I recommend non-certification of the requested lumbar CT/myelogram.

CT & CT Myelography (computed tomography)

Not recommended except for indications below for CT. CT Myelography OK if MRI unavailable, contraindicated (e.g. metallic foreign body), or inconclusive. ([Slebus, 1988](#)) ([Bigos, 1999](#)) ([ACR, 2000](#)) ([Airaksinen, 2006](#)) ([Chou, 2007](#)) Magnetic resonance imaging has largely replaced computed tomography scanning in the noninvasive evaluation of patients with painful myelopathy because of superior soft tissue resolution and multiplanar capability. Invasive evaluation by means of myelography and computed tomography myelography may be supplemental when visualization of neural structures is required for surgical planning or other specific problem solving. ([Seidenwurm, 2000](#)) The new ACP/APS guideline as compared to the old AHCPR guideline is more forceful about the need to avoid specialized diagnostic imaging such as computed tomography (CT) without a clear rationale for doing so. ([Shekelle, 2008](#)) A new meta-analysis of randomized trials finds no benefit to routine lumbar imaging (radiography, MRI, or CT) for low back pain without indications of serious underlying conditions, and recommends that clinicians should refrain from routine, immediate lumbar imaging in these patients. ([Chou-Lancet, 2009](#)) Primary care physicians are making a significant amount of inappropriate referrals for CT and MRI, according to new research published in the *Journal of the American College of Radiology*. There were high rates of inappropriate examinations for spinal CTs (53%), and for spinal MRIs (35%), including lumbar spine MRI for acute back pain without conservative therapy. ([Lehnert, 2010](#))

**Indications for imaging -- Computed tomography:**

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- 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)