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Notice of Independent Review Decision

Reviewer's Report

DATE OF REVIEW: March 15, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Myelogram/CT of lumbar and cervical spine (62284, 72126, 72132).

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

M.D., Board Certified in Physical Medicine and Rehabilitation.

REVIEW OUTCOME

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

[ ] Upheld (Agree)

[ ] Overturned (Disagree)

[X] Partially Overturned (Agree in part/Disagree in part)

The requested myelogram/CT of the lumbar spine (62284, 72132) is medically necessary for treatment of the patient's medical condition; however, the requested myelogram/CT of the cervical spine (62284, 72126) is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 2/10/11.

2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 2/23/11.
3. Notice of Assignment of Independent Review Organization dated 2/23/11.
4. Medical records from MD dated 12/31/10 and 12/21/10.
5. Medical record from MD dated 11/19/10.
6. Imaging dated 11/9/10.
7. Denial documentation.
8. Excerpt from Official Disability Guidelines (ODG).

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a XX-year-old male who fell on some steps at work on XX/XX/XX and hit his back and jarred his neck during the fall. Per the record, approximately X weeks following the injury the patient began experiencing neck pain, headaches, pain between his shoulder blades, and upper arm pain and numbness in his left hand and three fingers of his left hand. He also began experiencing pain in his lower back area, hips and pain in his anterior legs. The provider's notes indicate the patient failed trials of the following pharmacological agents: Mobic, hydrocodone, Flexeril and steroids; as well as physical therapy. An MRI study of the patient's lumbar spine was performed on 11/9/10 which revealed disc space dessication throughout the lumbar spine along with disc space narrowing, relatively sparing L2-3, and more prominent at L4-5, where there was moderate degenerative disc disease. An MRI of the cervical spine performed on the same date revealed mild straightening of the cervical spine in the AP dimension. Mild scoliotic curvature of the cervicothoracic spine was also identified. Additionally, there was a component of congenital narrowing in the AP dimension of the central canal of the cervical spine on the basis of short pedicles, particularly C6 through mid-body T1. Prominent spondylosis was noted throughout the mid cervical spine.

The provider recommends a lumbar and cervical myelogram with CT scans following the myelogram to aid in the determination of how much compression the patient has on the spinal cord and nerve roots in his cervical and lumbar spine. The provider indicates that the study will also help determine how much movement the patient has in his lumbar spine at the L5-S1 level and what type of surgery the patient may require. The URA indicates the requested services are not medically necessary. Specifically, the URA states that there are limited significant neurological findings or indications of any significant progression of signs and symptoms to consider surgical interventions that may require myelography/CT for pre-operative planning. The URA additionally states that there is limited evidence of exhaustion of prior conservative care from participation in evidence-based physical treatments to consider surgical intervention.

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

With regard to the requested lumbar myelogram/CT, as the patient's physician states, the service has been requested for staging of the patient in anticipation of lumbar spine surgery. According to Official Disability Guidelines (ODG), "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

patient has an L5 pars defect which usually requires fusion and/or some type of stabilization when lumbar spine surgery is anticipated. The myelogram/CT gives the surgeon a better indication of what the boney architecture is when planning surgery and what approach will be needed for a successful surgery. This patient has participated in conservative therapy and has not recovered his lost function. Therefore, he is an appropriate candidate for pre-surgical workup with myelogram/CT of the lumbar spine. As such, the requested myelogram/CT of the lumbar spine (62284, 72132) is medically necessary.

With regard to the requested myelogram/CT of the cervical spine, the patient does not have any indications for this service based upon the information provided. ODG does not support the use of myelogram/CT in this setting. There is no evidence the patient has a pacemaker or metallic implants that would contraindicate the use of another imaging modality. Further, the submitted records demonstrate the patient recently underwent a cervical MRI which is considered a superior procedure to determine soft tissue damage which appears to be present in this case. There is no indication for myelogram/CT of the cervical spine in anticipation of surgery. All told, the requested myelogram/CT of the cervical spine (62284, 72126) is not medically necessary for treatment of this patient's condition.

For the reasons stated above, I have determined that although the requested myelogram/CT of the lumbar spine (62284, 72132) is medically necessary, the requested myelogram/CT of the cervical spine (62284, 72126) is not medically necessary.

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

[**X**] 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)