

True Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/28/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CT Myelogram Lumbar

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

MD board certified orthopedic surgery

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. Utilization review determination 05/23/11 regarding non-certification appeal CT myelogram lumbar
2. Utilization review determination 05/05/11 regarding non-certification CT myelogram lumbar
3. Initial consultation and follow up reports Dr. 03/16/10 through 05/12/11
4. MRI lumbar spine 03/29/10
5. EMG/NCV 05/13/10
6. Operative report right L5 selective nerve root block 04/04/11
7. Follow up assessment SNRB
8. Procedure note lumbar epidural steroid injection and epidurography 09/14/10
9. Physical therapy initial evaluation 01/18/10
10. Work status reports
11. notes

PATIENT CLINICAL HISTORY SUMMARY

Records indicate that she was injured when walking and a chair was pulled out and she fell over the top of it falling backwards and hitting her head. There was no loss of consciousness. The injured employee had some physical therapy which helped a bit. MRI of the lumbar spine dated 03/29/10 reported minimal annular disc bulges at L3-4 and L4-5 which produced no significant neural impingement with minimal bilateral facet joint hypertrophy at L4-5 and L5-S1. There was slight desiccation of the L3-4 intervertebral disc space. There was no significant interval change from previous study of 09/14/09. Electrodiagnostic testing performed 05/13/10 reported findings consistent with an

acute/ongoing/evolving right L5 radiculopathy and left L5 paraspinal radiculopathy. Nerve conduction studies were consistent with a bilateral tibia peroneal motor neuropathy, right saphenous and left superficial peroneal sensory neuropathy, and absent peroneal F-wave supporting a bilateral L5 radiculopathy, left tibial F-wave support left S1 radiculopathy. Records indicate the injured employee underwent lumbar epidural steroid injection on 09/14/10. A right L5 selective nerve root block was performed on 04/04/11. The injured employee was seen in consultation by Dr. on 03/16/10 with complaints of low back pain radiating into the right lower extremity. Physical examination reported the injured employee to be 4'11" tall and 150 pounds. The injured employee has normal gait. She has difficulty with tandem walking. She has increased pain with lumbar extension more than flexion. There was decreased strength on the right side, and sensation decreased on the right through the L5-S1 dermatome. There was increased patellar reflex bilaterally. There were no long track signs. Seated straight leg raise was negative. Follow up note on 04/19/11 indicated the injured employee had a great response with selective nerve root block and had 100% relief of pain for the first four hours and then on day two her pain went back to an 8 after the injured employee returned to work. The injured employee was recommended to undergo CT myelogram.

A request for CT myelogram of the lumbar spine was reviewed on 05/05/11 and determined as not certified as medically necessary. Review noted the rationale for the request for CT myelogram of the lumbar spine was to be able to follow the L5 nerve root to see if the injured employee has any mechanical compression along the nerve root. However medical records have not provided objective documentation to first confirm whether the injured employee has failed conservative care including the use of physical therapy, pain medications and exercises. Also there is no clear discussion provided as to why this request is preferred over an MRI. There also was no discussion provided whether surgical procedure was currently being contemplated on this injured employee. Further physical examination on follow up report dated 04/19/11 was not provided. Therefore the request was not substantiated as medically necessary.

An appeal/reconsideration request for CT myelogram of the lumbar spine was reviewed on 05/23/11 and recommended as non-certified. It was noted that in the report the injured employee presented with pain in her back radiating down the leg, but the records submitted did not provide objective documentation regarding failure of conservative care such as physical therapy and exercises. There was a physical therapy initial evaluation report, but no progress notes documenting the injured employee's clinical and functional response to treatment were provided. There also was no indication that there were contraindications to performing MRI study in the injured employee. Lastly there was no documentation in the most recent medicals regarding comprehensive physical examination. As such certification for the requested CT myelogram was not established.

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

Based on the clinical data presented, the request for CT myelogram of the lumbar is not indicated as medically necessary. The injured employee sustained an injury on when she tripped and fell over a chair. She has subjective complaints of low back pain radiating to the right leg. There is no current physical examination provided with evidence of motor, sensory or reflex changes. The injured employee previously underwent lumbar MRI on 03/29/10 which revealed minimal disc bulges and facet hypertrophy of the lumbar spine with no focal disc protrusion and no central canal stenosis or foraminal narrowing. Per ODG guidelines, CT myelogram is not generally recommended for lumbar spine. It may be an option if MRI is unavailable, contraindicated or inconclusive. The records do not demonstrate that any of these conditions apply. Medical necessity is not established for CT myelogram lumbar.

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

- 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)