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## Notice of Independent Review Decision

**DATE OF REVIEW:** 9/2/11

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of an outpatient lumbar myelogram/CT.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

**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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of an outpatient lumbar myelogram/CT.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr.: 3/16/09 to 7/18/11 office notes by MD, 6/18/10 operative report and 3/16/09 radiographic report.

7/25/11 denial letter, 8/2/11 denial letter, 8/4/11 letter by Dr. office, 3/31/10 operative report, 3/31/10 lumbar myelogram report, 3/31/10 lumbar CT report, 2/17/09 discharge summary, 2/17/09 operative report and 2/17/09 history and physical report.

8/17/11 letter, 5/24/11 peer review, 11/16/09 DD report by MD, 6/18/10 operative report, 3/31/10 radiology progress notes, 3/31/10 physician order, 3/31/10 discharge instructions, 9/25/07 to 1/31/10 lumbar radiographic reports, 2/17/09 neurodiagnostic report, 1/21/09 lumbar myelogram and CT reports, 12/12/08 lumbar MRI report, 2/8/08 lumbar myelogram and CT reports, 5/7/07 lumbar CT report, 10/27/06 lumbar MRI report, 6/22/07 neurodiagnostic report, 2/27/08 operative report,

A copy of the ODG was not provided by the Carrier or URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant was injured on xx/xx/xxxx. He is status post a L4-5 lumbar fusion (after a prior procedure) on 2/17/09. Most recently as of 7/18/11, the claimant was noted to have increased back pain with bilateral hip/leg radiation, along with paresthesias and quadriceps weakness. The claimant is status post a prior CT/myelogram. The prior 3/31/10 dated CT-myelogram revealed post-op changes and the previously noted "mild" evidence of L3-4 stenosis "as before." Prior treatment records of epidural steroid injections were noted. Prior denial letters indicated the lack of objective neurologic progression, inconsistent or minimal objective abnormalities and unclear documentation of non-operative treatments.

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

Documentation supports that the claimant has had a progression of lumbar spine pathology with objectively increased "neurological deficit", an ODG criterion for a CT scan. The most recent note dated 7/18/11 evidences quadriceps weakness and an abnormal gait, in addition to the subjective back and bilateral leg pain with paresthesias. In light of the greater weakness in the quadriceps and increased pain and paresthesias, a new CT-myelogram is both reasonable and medically necessary as per ODG criteria.

Reference: ODG-Lumbar Spine/Imaging Studies-CT Scan, Myelogram

Indications for imaging

Myelography: Recommended as an option. Myelography OK if MRI unavailable. (Bigos, 1999)

Computed tomography: 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

**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)