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Notice of Independent Review Decision

DATE OF REVIEW: 2/1/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of myelography, lumbosacral, radiological supervision and interpretation.

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 agrees with the previous adverse determination regarding the prospective medical necessity of myelography, lumbosacral, radiological supervision and interpretation.

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 office notes by 10/28/10 to 9/1/11, 1/12/2009 lumbar MRI with and without contrast, 11/26/08 thoracic MRI report, 11/25/08 lumbar MRI report, 6/1/10 lumbar MRI report, 1/27/11 cervical MRI report, 11/25/08 cervical MRI report, 9/22/08 thoracic radiographic report, 1/13/09 lumbar MRI report, 9/22/08 thoracic CT report, 8/1/10 lumbar MRI report and 1/13/09 lumbar MRI report. 1/17/12 letter by 12/29/11 denial letter, 1/5/12 letter

about review process, 1/9/12 denial letter, 12/29/11 report by 1/9/12 report by 12/1/11 DWC 73, 12/1/11 notes by 6/6/11 report by 6/8/11 IRO decision, 4/26/11 report by UR request of 12/8/11, patient demographic sheet, CT myelogram script by 12/17/08 neurodiagnostic report by and 1/5/12 letter by.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

Clinical notes from the treating provider and URA were reviewed. The claimant's neck and back pain with radiation into the extremities was noted, as per. Reduced knee and ankle reflexes were noted. Motor power was inconsistently documented to be 4/5 bilaterally and also 5/5 in the bilateral lower extremities. A positive straight leg raise was noted. Prior AP records were reviewed, with normal lower extremity strength noted. On 12/1/11, there was no examination but ongoing back complaints. Electrical studies noted chronic left L5 and right S1 radiculopathy, on 12/17/08. A 6/1/10 dated lumbar MRI revealed degenerative changes, including an annular tear, along with no evidence of nerve root impingement. A 1/13/09 dated lumbar MRI revealed an annular tear at L5-S1. The claimant indicated that his symptoms of neck and back pain were worsening. Surgical fusion was felt indicated at L5-S1.

Denial letters noted the lack of clear rationale for the requested diagnostics, especially in light of there being available 2 prior MRI reports. In addition, the lack of progressive neurological deficit and lack of being a surgical candidate was additional rationale for denials.

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

Without documentation of any consistent and/or progressive neurologic deficit, and, with prior and conclusive MRI reports that have not changed over time; there is no medical indication for any additional imaging study/radiologist supervision/interpretation at this time, as per applicable clinical guidelines. Therefore, the request procedure is not medically necessary at this time.

Reference: ODG Myelography

Not recommended except for selected indications below, when MR imaging cannot be performed, or in addition to MRI. Myelography and CT Myelography OK if MRI unavailable, contraindicated (e.g. metallic foreign body), or inconclusive. 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. Myelography and CT Myelography have largely been superseded by the development of high resolution CT and magnetic resonance imaging (MRI), but there remain the selected indications below for these procedures, when MR imaging cannot be performed, or in addition to MRI.

ODG Criteria for Myelography and CT Myelography:

1. Demonstration of the site of a cerebrospinal fluid leak (post lumbar puncture headache, post spinal surgery headache, rhinorrhea, or otorrhea).
2. Surgical planning, especially in regard to the nerve roots; a myelogram can show whether surgical treatment is promising in a given case and, if it is, can help in planning surgery.
3. Radiation therapy planning, for tumors involving the bony spine, meninges, nerve roots or spinal cord.
4. Diagnostic evaluation of spinal or basal cisternal disease, and infection involving the bony spine, intervertebral discs, meninges and surrounding soft tissues, or inflammation of the arachnoid membrane that covers the spinal cord.
5. Poor correlation of physical findings with MRI studies.
6. Use of MRI precluded because of:
 - a. Claustrophobia
 - b. Technical issues, e.g., patient size
 - c. Safety reasons, e.g., pacemaker
 - d. Surgical hardware

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)