

# I-Resolutions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Dec/19/2011

**IRO CASE #:**

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

Lumbar myelogram with CT

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

M.D., Board Certified Neurological 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**

Official Disability Guidelines

Preauthorization adverse determination 11/10/11

Appeal preauthorization adverse determination 11/28/11

Preauthorization / precertification request 11/07/11

Preauthorization / precertification request 11/10/11

Neurosurgical consultation Dr. 10/06/11

Office notes Dr. 10/24/11

MRI lumbar spine 09/27/11

MRI cervical spine 09/27/11

Electrodiagnostic results 10/05/11

Letter of medical necessity D.C. 11/15/11

Initial clinical interview NCC, LPC 11/11/11

IRO summary letter Dr. 11/30/11

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who was injured on xx/xx/xx while unloading a truck with a forklift. The truck moved forward and the forklift dropped off the back end of truck about 5 feet to ground. The claimant reported acute onset of low back pain with radiation into right lower extremity. MRI of lumbar spine performed on 09/27/11 revealed disc desiccation L4-S1 with moderate thinning of disc at L4-5. At L4-5 there is a 4-5 mm broad based disc protrusion effacing the ventral epidural space minimally contacting the anterior margin of descending L5 nerve root on both sides and narrowing the neural foramina in moderate fashion bilaterally. At L5-S1 there is a 1-2 mm broad based disc protrusion effacing the ventral epidural fat minimally narrowing the neural foramina bilaterally. There is subtle lumbar hyperlordosis associated with degenerative subluxation at L4 on L5 approximately 4-5 mm; cannot exclude unilateral or bilateral pars fractures at L4. Electrodiagnostic testing performed on 10/05/11

reported only significant abnormalities or fibrillations in L5 and S1 paraspinal muscles and right L5 and S1 paraspinal muscles, which abnormalities were noted to indicate radiculopathy at L5 and S1 bilaterally. The claimant was treated conservatively with physical therapy and medications without significant improvement. The claimant was seen on 10/06/11 for neurosurgical consultation. On physical examination the claimant is noted to be 5'9" tall and 282 lbs with BMI of 41.6. Lumbar range of motion was decreased in forward flexion secondary to pain and body habitus. Motor exam revealed 4/5 strength in tibialis anterior and EHL muscle on right, otherwise 5/5 throughout. Deep tendon reflexes were +2 throughout and symmetrical. Plantar Responses were flexor bilaterally. Gait was antalgic. The claimant had marked difficulty with heel walking, less difficulty with toe walking and no difficulty with tandem walking. Straight leg raise was positive bilaterally at 50 degrees.

Sensory exam revealed a hypoesthetic region in L5 distribution on right to pinprick and light touch, otherwise intact. Coordination was intact. Dr. recommended CT myelogram of lumbar spine to better evaluate lumbar spondylolisthesis at L4-5, rule out pars defects for surgical planning.

A preauthorization review dated 11/10/11 resulted in adverse determination of request for lumbar myelogram CT. It was noted lumbar MRI on 09/27/11 showed 4-5 mm subluxation of L4 on L5 and 4-5 mm disc protrusion at L4-5. EMG/NCV on 10/05/11 showed findings in paraspinal muscles only. On clinic note dated 10/05/11, Dr. noted the claimant complains of low back pain that radiates to right lower extremity. Pain levels are 5-6/10. Exam is reported to show 4/5 strength of anterior tibialis and EHL on right and decreased sensation in L5 distribution. Epidural steroid injection was recommended. Clinic note dated 10/24/11 Dr. noted the claimant reported low back pain. There was no mention of radicular symptoms. Pain level was 5/10. Exam only showed lumbar tenderness, decreased motion, no motor or sensory deficits, and negative straight leg raise. Dr. recommended facet injections, which were recently authorized. The case was discussed with Dr. who stated the study was ordered to evaluate pars defects and for presurgical planning. He stated surgery would be indicated if there is instability. He was not aware of evaluation by Dr. or recently authorized medial branch blocks. The requested lumbar CT myelogram is denied noting there was no explanation as to completely different exam findings by two physicians within a few weeks of each other. Spinal instability can be evaluated by plain film extension / flexion views. Invasive study like CT myelogram does not appear to be indicated with information provided.

An appeal request was reviewed on 11/28/11 and adverse determination was recommended. It was noted the claimant had MRI. The provider stated he needed myelogram / CT to evaluate for pars defect. In discussing the case with Dr. he said myelogram CT was needed for surgical planning, i.e. laminectomy versus laminectomy and fusion. He said the claimant had known pars defect based on MRI. Plain x-rays, i.e. obliques, etc. may be indicated to determine if the claimant has pars defect. The myelogram is not indicated to determine existence of pars defect. Stability can be assessed with flexion / extension x-rays. Myelogram CT is not indicated to assess stability.

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

The claimant sustained an injury to the low back on xx/xx/xx. He complained of low back pain radiating to right lower extremity. MRI revealed a subtle lumbar hyperlordosis associated with degenerative subluxation at L4 upon L5 approximately 4-5 mm and a unilateral or bilateral pars fracture could not be excluded. There was a 4-5 mm broad based disc protrusion at L4-5 and 1-2 mm broad based disc protrusion at L5-S1. EMG/NCV reported only significant abnormality for fibrillation in bilateral L5 and S1 paraspinal muscles. The records indicate the claimant had been approved for facet / medial branch blocks after evaluation by Dr.. It was noted that the clinical examination findings by two different providers only 2 weeks apart were different. As noted on previous reviews, evaluation of possible pars defects and motion segment instability can be obtained through plain radiographs with flexion / extension views. As such, the reviewer finds there is no medical necessity for Lumbar myelogram with CT.

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

ACOEM-AMERICA 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)