

Notice of Independent Review Decision

DATE OF REVIEW: 06/05/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Myelography, Cervical, Radiological Supervision and Interpretation

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

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. He is certified in pain management. He is a member of the Texas Medical Board. He has a private practice of Physical Medicine & Rehabilitation, Electro Diagnostic Medicine & Pain Management in Texas. He has published in medical journals. He is a member of his state and national medical societies.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Upon independent review, I find that the previous adverse determination or determinations should be Upheld.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records Received: 18 page fax 05/30/12 Texas Department of Insurance IRO request, 43 page fax 05/30/12 URA response to disputed services including

administrative and medical records. Dates of documents range from 06/28/02 to 05/30/12.

PATIENT CLINICAL HISTORY [SUMMARY]:

man who sustained a work related injury to the lumbar spine xx/xx/xx when exiting an airport bus. S/P lumbar decompression fusion L4/5 and L5/S1 in 1989 and 199. Permanent lumbar SCS implanted in 2006. Repeat laminectomies bilaterally at L1/2, L2/3, L3/4 foraminotomies with partial facetectomies. Exploration of L2, L3, and L4 nerve roots was done along with removal of SCS and battery in 2007. SCS re-implanted 2009. Possible recent symptoms in the neck and left upper extremity.

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

Review of the original denials indicated a lack of any surgical planning and lack of documentation why MRI imaging could not be performed as recommended in the ODG. None of this information was refuted or discussed in the IRO submission. Does not meet ODG criteria.

ODG REFERENCE

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. (Slebus, 1988) (Bigos, 1999) (ACR, 2000) (Airaksinen, 2006) (Chou, 2007) 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. (Seidenwurm, 2000) 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. (Mukherji, 2009)

ODG Criteria for Myelography and CT Myelography:

- 1. Demonstration of the site of a cerebrospinal fluid leak (postlumbar puncture headache, postspinal 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*

- *ACOEM-American College of Occupational & Environmental Medicine*
- *ODG-Officiat Disability Guidelines & Treatment Guidelines.*

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)**