



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 3/5/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a lumbar myelogram with 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.

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 a lumbar myelogram with 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 Appeal Letter – 2/7/12, Office Visit Note – 8/24/11, 9/6/11, & 11/22/11, Treatment Plan – 8/26/11; Electrodiagnostic Reports – 5/15/08 & 10/4/11; Scheduling Sheet – undated; SOAP Notes – 9/1/11 & 1/19/12; Script – 8/24/11; and Operative Report – 6/8/11.

Records reviewed from All records were duplicates from above.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The provider's letter dated 2/7/12 discussed that the patient is status post spinal surgery for a fractured at T12. "She has had complications from the surgery." The requested CT myelogram is "...to evaluate the neural structures, especially at L2-3 and to rule out pseudarthrosis." This is a pre-operative revision diagnostic. Bilateral L3 radiculopathy had been noted in 2008 dated electrical studies. More recently on 10/4/11, a left L4 radiculopathy was noted. Records from 1/19/12 reveal that there was a prior T12 fracture with retropulsion that was treated with anterior posterior fusion including long strut graft and also a posterior fusion from T10-L3. The patient has had recurrent back, groin and anterior thigh pain. Weak bilateral iliopsoas was noted on examination. A 6/14/10 dated CT-myelogram discussed a possible pseudarthrosis at L2-3 in particular. Serial x-rays and an addition CT scan were noted to reveal possible strut and/or L2-3 nonunion. A CT-myelogram was felt indicated by the Attending Physician. This was also to assess potential aorta or spinal cord impingement. If so, then there would be a surgical indication, as per the Attending Physician.

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

With the persistent pain and x-ray evidence of potential strut impingement (on critical structures) and/or L2-3 nonunion, ODG criteria have been met regarding plausible surgical planning. In fact, the outcome of such a diagnostic testing may well be determinative of surgical vs. a non-surgical approach in the patient's treatment options. As per ODG criteria "a myelogram can show whether surgical treatment is promising in a given case and, if it is, can help in planning surgery." Therefore, the request is medically necessary.

ODG Lumbar Spine: Indications for imaging -- 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 (Laasonen, 1989)

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)