

Icon Medical Solutions, Inc.

11815 CR 452
Lindale, TX 75771
P 903.749.4272
F 888.663.6614

Notice of Independent Review Decision

DATE OF REVIEW: April 30, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

62284, Injection Procedure for Myelo &/or CAT Scan, 72132 CAT Scan, lumbar spine; with contrast, 72265 Myelography Lumbosacral – RAD S, 72114 X-Ray Exam of Lower Spine

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

This physician is Board Certified by American Board of Orthopedic Surgeons with over 40 years of experience.

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

01/29/10: MRI of Lumbar Spine without Contrast interpreted by MD

04/01/10: Initial Visit by MD with Spine Institute

05/06/10: Office Note by MD with Spine Institute

08/10/10: Pain Management Consultation by DO with Pain Associates, PA

12/15/10: Operative Report by MD

04/12/11: Pain Management Followup by DO with Pain Associates, PA

06/07/11: SOAP Note by DO with Pain Associates, PA

07/19/11: Initial Comprehensive Evaluation by DO with Medical Clinic

08/12/11: Operative Report by DO
09/27/11: Physical Performance Evaluation by with Center
10/12/11: Pre-Surgical and Behavioral Medicine Consultation by LBSW-IPR and LCSW
10/25/11: Peer Review Report by MD
03/05/12: Letter of Medical Necessity by MD
03/13/12: UR performed by MD
03/21/12: UR performed by MD

PATIENT CLINICAL HISTORY [SUMMARY]:

This female was injured on xx/xx/xx when she tried to keep a student from falling and twisted her back. Her treatment has included chiropractic care, passive modalities, physical therapy modalities, facet injections, and facet rhizotomy.

01/29/10: MRI of Lumbar Spine without Contrast. Impression: 1. Bilateral spondylolysis (pars defect) of the L5 vertebra with grade II spondylolisthesis of L5 over S1 vertebra causing narrowing of the foramina bilaterally. Pseudoannular bulge of the intervening disc compressing the exiting L5 nerve root bilaterally. 2. Mild diffuse annular bulge with medium sized central protrusion and posterior annular tear of L4-5 disc indenting the thecal sac. Mild ligamentum flavum hypertrophy and facet osteoarthropathy at this level. 3. Mild diffuse annular bulge of L1-2 and L3-4 discs indenting the thecal sac. Mild facet osteoarthropathy at these levels. 4. Desiccation and loss of height of the discs as above.

04/01/10: The claimant was evaluated by MD. On physical examination she was able to toe and heel walk. She had equal pain with both forward flexion and extension and had slightly decreased range of motion with extension. EHL, DF, PF, Q and H were 4+/5 bilaterally. She had decreased sensation on the lateral aspect of her right foot as well as the lateral aspect of her leg. DTRs were 1+ at the patellar, diminished at the Achilles bilaterally. Negative FABER sign. Negative log roll sign. She did have significant pain to palpation over her lumbar spine. She did not have any significant pain over her SI joints bilaterally. Dr. diagnosed spondylolysis L5-S1, Grade 2 spondylolisthesis, foraminal stenosis, right wrist ganglion cyst and right wrist sprain. She was started on an active physical therapy program along with anti-inflammatories

05/06/10: The claimant was re-evaluated by MD who noted she had completed 5 sessions of therapy which only exacerbated her symptoms. No change in PE. Dr. recommended facet injections since she failed physical therapy and anti-inflammatory management.

08/10/10: The claimant had a Pain Management Consultation with, DO who noted she tried approximately 15 sessions of PT, and medications including Meloxicam, Ibuprofen, Naprosyn, and Tramadol. On physical examination her motor strength was 5/5 in the bilateral L3 through S1 myotomes. Sensation to light touch was intact in the bilateral L3 through S1 dermatomes. DTRs were 1+ and symmetric in the bilateral patella and Achilles reflexes. There was bilateral

paraspinal muscle tenderness to palpation extending from the L4 to S1 area. There was pain with facet loading of the lumbar spine, right greater than left. There was a negative FABER's, negative straight leg raise, negative trochanteric tenderness to palpation and there was no reproduction of hip pain with internal or external rotation. Impression: L5-S1 Grade II spondylolisthesis and spondylolysis/pars defect, lumbar facet pain syndrome, lumbar HNP and right wrist sprain. Dr. stated that the claimant's low back symptoms were most likely related to her lumbar facet pain and her L5-S1 spondylolisthesis. Dr. recommended bilateral L3, L4, and L5 diagnostic medial branch blocks and depending on her response, she would consider following up with rhizotomy. She was also given a prescription of Meloxicam 15 mg.

12/15/10: Operative Report by MD. Postoperative Diagnosis: Lumbar facet syndrome. Procedure performed: Fluoroscopically guided left L3, L4, and L5 medial branch rhizotomy and branch blocks.

04/12/11: The claimant was re-evaluated by DO who reported that she presented with low back pain across the L4 to S1 area, left greater than right. Her pain was re-aggravated approximately 2 weeks ago with no specific traumatic event, and she had been doing quite well before that. It was noted she had a left lumbar rhizotomy on 12/15/10 and a right lumbar rhizotomy on 11/17/10, which gave her significant relief for almost 6 months. On physical examination motor strength was 5/5 in the bilateral L3 through S1 myotomes. Sensation to light touch was intact in the bilateral L3 to S1 dermatomes. DTRs were 1+ and symmetric in the bilateral patella and Achilles reflexes. There was bilateral paraspinal muscle tenderness to palpation extending from the L4 to S1 area. There was pain with facet loading of the lumbar spine, right greater than left. There was negative FABER's, negative straight leg raise, negative trochanteric tenderness to palpation and there was no reproduction of hip pain with internal or external rotation. Dr. recommended repeat bilateral L3, L4, and L5 needle branch rhizotomy. She was also given a prescription for Hydrocodone.

06/07/11: The claimant was re-evaluated by DO who reported that she presented with low back pain rated 9/10 and that was across the L4 to S1 area, right greater than left. It was noted that most recently she had to take more hydrocodone due to the worsened pain. Dr. noted that the claimant had found a new treating physician at Medical and that she saw Dr.. Dr. office spoke to the claimant's pharmacy, and in addition to the hydrocodone Dr. prescribed her on 4/13/11 #60, she got hydrocodone 5/500 #30 from her PCP, Dr., and Tramadol #60 from Dr. on 5/25/11. Dr. reviewed their opioid policy with her. On physical examination, motor strength was 5/5 and sensation was intact in the bilateral L3 through S1 myotomes. DTRs were 1+ and symmetric in the bilateral patella and Achilles reflexes. No upper motor neuron signs. There was bilateral paraspinal muscle tenderness to palpation extending from the L4 to S1 area. There was pain with facet loading of the lumbar spine, right greater than left. There was a negative FABER's. Positive right straight leg raise, negative left SLR, negative trochanteric tenderness to palpation, and no reproduction of hip pain with internal or external

rotation. Dr. recommended repeat bilateral L3, L4, and L5 medial branch rhizotomy to address the bilateral L4-5 and L5-S1 facet joints. She was given a prescription to increase her hydrocodone to 10/325 q. 12h. p.r.n. pain #60 no refills. Dr. stated that it would be the last opioid prescription from her.

07/19/11: The claimant was evaluated by DO who reported that she was seen for feeling pain in the lower back area. She had constant severe inflexibility and restricted movement and stiffness as well as shooting, sharp, stinging, and throbbing pain radiating to the right posterior thigh and buttocks. On physical exam, she had strong pain to palpation at L1-L6 bilaterally. Spasms of the lumbar paraspinal muscles bilaterally were noted. Reflexes at the triceps, biceps, brachioradialis, hamstring, patella, and Achilles were 2/5 bilaterally. Babinski Sign was absent bilaterally. Hyperextension Test was positive bilaterally. Milgram's Test was positive bilaterally. Straight Leg Raise Test was positive on the right. Kemp's Standing Test was positive bilaterally. Valsalva's Test was positive. She had pain with lumbar range of motion. Lower extremity strength was rated at 4/5 with the exception of being 3/5 at the right gluteus medius, right gluteus maximus, right gluteus minimus, and right tensor fascia latae. An orthopedic evaluation was requested.

08/12/11: Operative Report by, DO. Postoperative diagnosis: Lumbar spondylosis without myelopathy. Procedure performed: Fluoroscopically guided bilateral L3, L4, and L5 medial branch rhizotomy.

09/27/11: Physical Performance Evaluation by with Center. Assessments: The evaluatee cannot safely perform their job demands based on comparative analysis between their required job demands and their current evaluation outcomes. Recommendations: A psychological evaluation for the evaluatee's emotional complications as a result of their injury and the surrounding problems with being off of work or work restrictions, which includes but is not limited to the possibility of depression and a lack of self worth. 2. The evaluatee should continue care with their treating doctor in order to help the evaluatee's condition, minimize and correct as well as reduce muscle spasms, decrease joint adhesions, increase range of motion, and decrease the perception of pain. 3. Any referrals the treating doctor feels is necessary that will help the evaluatee's condition. 4. The evaluatee would be a good candidate and should be referred for surgical consultation, if they haven't been already. 5. According to the objective findings from the testing including: PILE lifting, static lifting, the clinical examination, and all other activities previously mentioned in this report, it is my opinion that this evaluatee does not meet the requirements, safety, and performance ability to do their job safely, effectively, and confidently (without restrictions). The evaluatee is not capable of performing their job duties (without restrictions) until they demonstrate objective improvement and the ability to perform safely and efficiently at their place of employment.

10/12/11: Pre-Surgical and Behavioral Medicine Consultation by LBSW-IPR and LCSW. Multiaxial Diagnosis: Axis I: Pain disorder associated with both psychological factors and a general medical condition. Major depressive disorder,

single episode, moderate. Panic disorder. Axis II: no diagnosis. Axis III: Injury to right wrist and lumbar. Axis IV: Primary support group, Economic problems and Occupational problems. Axis V: GAF=51 (current). Recommendations: She has no overt psychopathology precluding her from surgery. She demonstrates understanding of risks associated with surgery and expresses concern that unexpected complications will arise. She relates being unsure if she will undergo surgery, in which she relates having only met with the surgeon on two separate occasions. She relates being fearful of undergoing lumbar surgery and is concerned about the risks of a failed back surgery. She indicated she would meet with the surgeon on a future date and gather information on surgery so that she can research and make an informed decision.

03/05/12: Letter of Medical Necessity by MD. The rationale for a fusion at the L5-S1 level is to stabilize the spondylolisthesis. The L4-L5 level will need a bilateral facetectomy, thereby causing surgically induced instability, which will require a fusion as well. I would like to order a myelogram with flexion and extension X-rays to better evaluate the spondylolisthesis at L5-S1 and the neurological structures at L4-L5 for surgical planning purposes.

03/13/12: UR performed by MD. Rationale: This patient has already been evaluated for a spine fusion which was appealed to the IRO level and the denial upheld. The need for a myelogram CT study is not validated by these records as it would be considered a study for a patient who has been approved or pending surgery. This spine surgery has already been assessed for necessity and denied.

03/21/12: UR performed by MD. Rationale: I discussed the case with Dr. who stated that he has been authorized to do the peer to peer call on behalf of Dr.. He wasn't able to add any further information regarding need for the CT Myelogram and without any further information, this request cannot be certified. The claimant underwent a prior utilization review for anteroposterior spinal fusion from L4 to S1 with L5-S1 Gill decompression, which was denied 12/14/11 and again 12/28/11 on reconsideration. An IRO upheld denial of fusion surgery 1/20/12. The requesting physician still wants to move forward with fusion. The request was denied 3/13/12. A required medical examination designated doctor examination was performed 12/13/10, at which time the claimant was placed at MMI with zero percent impairment rating as surveillance video as of September 2010-October 2010 showed the injured employee cleaning a window, carrying a bag, swinging plastic bags, driving, opening and closing doors all without any undue pain behavior. The review performed 10/25/11 by Dr. indicated that the diagnosis of lytic spondylolisthesis was a congenital defect at L5-S1 which was not aggravated, accelerated, or exacerbated by the compensable event of injury and that at the time the grade 2 spondylolisthesis was identified, the claimant had no complaints of radiation of pain into the lower extremities and no complaints of low back pain. A letter of medical necessity was submitted by requesting physician, Dr. 3/5/12 for a CT myelogram with flexion/extension x-rays. Dr. indicated that the claimant had ongoing low back pain and had recent radiofrequency ablation and did not understand ongoing issues with complaints of low back pain stated to rate

8 on a scale of 0-10. The pain was described as constant with throbbing, shooting pain into the right leg and right lower extensor hallucis and gastrocnemius. Strength was stated to be 4/5, sensation decreased in the L5-S1 dermatome, reflexes were intact, quadriceps 1+ at the Achilles with negative clonus and Babinski. Straight leg raise testing was positive and the left extensor hallucis longus and gastrocnemius was also at 4/5 strength. 2+ intact reflexes at the quadriceps, 1+ at the Achilles with positive straight leg raise testing on the left. There was ongoing request for L5-S1 anteroposterior fusion with L5-S1 Gill decompression, rationalization of L5-S1 stabilization spondylolisthesis and that the claimant would need bilateral facetectomy at L4-L5 and that a CT myelogram with flexion/extension views was indicated to evaluate spondylolisthesis at L5-S1 and the neuro structures at L4 and L5 for surgical planning purposes. The claimant underwent a prior IRO which was upheld for denial of spinal fusion. The first spinal surgery was already medically assessed and denied. The claimant's spondylolisthesis was determined to be an ordinary disease of life. Based on the medical records available for review, the claimant has not had any progressive myopathy or neuropathy. The claimant has still intact reflexes at the Achilles, which are 1+, and at the knees, which are 2+. There is no documentation of atrophy into the lower extremities. Therefore, as there is not injury or progression of myopathy or neuropathy, ongoing extended diagnostic treatment is not medically supported. There is no new documentation to support additional treatment for diagnostic testing. The surgical planning for lumbar fusion of L4-S1 has been denied and upheld by an IRO. The request is not certified.

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

The previous adverse decisions are upheld. After reviewing her records, a CT myelogram is not indicated in this case. She has already had a request for surgery denied. There is no indication in her chart that there has been any change in her neurological condition since that request had been denied. She continues to have back pain, inconsistent neurological finding, and a pre-existing spondylolisthesis. A CT myelogram would not contribute any information that would help in her care and management.

ODG:

Myelography	<p>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)</p> <p>ODG Criteria for Myelography and CT Myelography:</p>
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	<ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> a. Claustrophobia b. Technical issues, e.g., patient size c. Safety reasons, e.g., pacemaker d. Surgical hardware
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Flexion/extension imaging studies	Not recommended as a primary criteria for range of motion. An inclinometer is the preferred device for obtaining accurate, reproducible measurements. See Range of motion (ROM); Flexibility . For spinal instability, may be a criteria prior to fusion, for example in evaluating symptomatic spondylolisthesis when there is consideration for surgery. See Fusion (spinal).
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Radiography (x-rays)	<p>Not recommend routine x-rays in the absence of red flags. (See indications list below.) Lumbar spine radiography should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least 6 weeks. However, some providers feel it “may” be appropriate when the physician believes it would aid in patient expectations and management. The theory is that this reassurance may lessen fear avoidance regarding return to normal activities and exercise, but this has not been proven. (Ash, 2008) Indiscriminant imaging may result in false positive findings that are not the source of painful symptoms and do not warrant surgery. A history that includes the key features of serious causes will detect all patients requiring imaging. (Kendrick, 2001) (Bigos, 1999) (Seidenwurm, 2000) (Gilbert, 2004) (Gilbert2, 2004) (Yelland, 2004) (Airaksinen, 2006) (Chou, 2007) According to the American College of Radiology, “It is now clear from previous studies that uncomplicated acute low back pain is a benign, self-limited condition that does not warrant any imaging studies.” (ACR, 2000) A Recent quality study concludes that MRI is no better than x-rays in management of low back pain, if the cost benefit analysis includes all the treatment that continues after the more sensitive MRI reveals the usual insignificant disc bulges and herniations. (Jarvik-JAMA, 2003) The new proposed HEDIS (Health plan Employer Data Information Set) report card on the use of imaging for low back is scheduled to go into effect on Jan 1, 2005. This new standard is the first one in which the issue is over utilization. In young and middle-aged adults, with new episodes of mechanical LBP, without any indication of comorbid complications, the new standard assumes that there is no indication for imaging. (HEDIS, 2004) The new ACP/APS guideline as compared to the old AHCPR guideline is similarly cautious about the use of plain x-ray imaging, but now more strongly supported by the availability of randomized trials showing no benefit for early x-ray imaging. (Shekelle, 2008) New research shows that healthcare expenditures for back and neck problems have increased substantially over time, but with little improvement in healthcare outcomes such as functional disability and work limitations. Rates of imaging, injections, opiate use, and spinal surgery have increased substantially over the past decade, but it is unclear what impact, if any, this has had on health outcomes. (Martin, 2008) A new meta-analysis of randomized trials finds no benefit to routine lumbar imaging (radiography, MRI,</p>
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	<p>or CT) for low back pain without indications of serious underlying conditions, and recommends that clinicians should refrain from routine, immediate lumbar imaging in these patients. (Chou-Lancet, 2009) Routine imaging for low back pain is not beneficial and may even be harmful, according to new guidelines from the American College of Physicians. Imaging is indicated only if patients have severe progressive neurologic impairments or signs or symptoms indicating a serious or specific underlying condition, or if they are candidates for invasive interventions. Immediate imaging is recommended for patients with major risk factors for cancer, spinal infection, cauda equina syndrome, or severe or progressive neurologic deficits. Imaging after a trial of treatment is recommended for patients who have minor risk factors for cancer, inflammatory back disease, vertebral compression fracture, radiculopathy, or symptomatic spinal stenosis. Subsequent imaging should be based on new symptoms or changes in current symptoms. (Chou, 2011) See also ACR Appropriateness CriteriaTM. See also Flexion/extension imaging studies.</p> <p><u>Indications for imaging -- Plain X-rays:</u></p> <ul style="list-style-type: none"> - Thoracic spine trauma: severe trauma, pain, no neurological deficit - Thoracic spine trauma: with neurological deficit - Lumbar spine trauma (a serious bodily injury): pain, tenderness - Lumbar spine trauma: trauma, neurological deficit - Lumbar spine trauma: seat belt (chance) fracture - Uncomplicated low back pain, trauma, steroids, osteoporosis, over 70 - Uncomplicated low back pain, suspicion of cancer, infection - Myelopathy (neurological deficit related to the spinal cord), traumatic - Myelopathy, painful - Myelopathy, sudden onset - Myelopathy, infectious disease patient - Myelopathy, oncology patient - Post-surgery: evaluate status of fusion
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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)**