

INDEPENDENT REVIEWERS OF TEXAS, INC.

4100 West Eldorado Pkwy' Suite 100 -373 . McKinney, Texas 75070
Office 469-218-1010 . Toll Free Fax 469-374-6852 e-mail: independentreviewers@hotmail.com

Notice of Independent Review Decision

[Date notice sent to all parties]:

12/20/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: APPEAL CT
Myelogram of Lumbar Spine, 72132 62284

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR
OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**
Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

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

Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Clinical note dated 05/15/12
Clinical note dated 06/06/12
Clinical note dated 07/24/12
Clinical note dated 08/29/12
Clinical note dated 09/10/12
Clinical note dated 11/06/12
Clinical note dated 11/28/12
Clinical note dated 01/18/13
Clinical note dated 02/05/13

Clinical note dated 02/19/13
Clinical note dated 04/16/13
Clinical note dated 05/15/13
Clinical note dated 07/16/13
Clinical note dated 10/07/13
Rehabilitation note dated 07/17/12
Rehabilitation note dated 08/20/12
Electrodiagnostic studies completed on 08/24/12
Radiology report dated 08/24/12
Behavioral medicine evaluation dated 09/26/12
Functional capacity evaluation dated 10/03/12
Functional capacity evaluation dated 10/24/12
Operative note dated 01/21/13
Rehabilitation note dated 02/12/13
Rehabilitation note dated 04/11/13
Rehabilitation note dated 05/07/13
Adverse determinations dated 10/14/13 & 10/29/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury regarding her low back. The clinical note dated 05/15/12 indicates the initial injury occurred prior to this office visit. The patient noted ongoing low back pain with associated stiffness and decreased range of motion throughout the lumbar region. Pain was located at the mid and left upper back. The patient described the pain as a sharp and aching sensation. The radiology report dated 05/24/12 revealed a grade 1 spondylolisthesis of L5. Mild to moderate bilateral foraminal narrowing was noted as well. The clinical note dated 11/18/12 indicates the patient continuing with low back pain. The note mentions the patient utilizing Skelaxin, Lyrica, and Tramadol for ongoing pain relief. Paresthesia was noted at the L5, S1, and S2 distributions on the left. Range of motion deficits were noted throughout the lumbar region. The operative note dated 01/21/13 indicates the patient having undergone a posterior fusion with an allograft at the L5-S1 level. The clinical note dated 04/16/13 indicates the patient reporting benefit following the previous surgery. The note indicates the patient utilizing Celebrex for ongoing pain relief. The therapy note dated 05/07/13 indicates the patient continuing with feelings of stiffness in the lumbosacral region. The patient rated the ongoing pain as 4/10. The clinical note dated 05/15/13 indicates the patient continuing with complaints of severe pain in the low back. Paresthesia was noted in the L4 through S2 distributions on the left. Reflex deficits were noted at the left knee and absent from the left ankle. Tenderness was noted at the lumbar and sacral vertebrae. The clinical note dated 07/16/13 indicates the patient complaining of radiating pain into the lower extremities. X-rays completed revealed good position of the implants. No loosening was noted. The clinical note dated 10/07/13 indicates the patient complaining of low back pain with radiating pain into both lower extremities. The patient was noted to have been diagnosed with multiple sclerosis at that time. The note indicates the patient having sustained a fall resulting in a wrist injury. The patient was recommended for a CT myelogram at that time.

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

The documentation submitted for review elaborates the patient complaining of low back pain with radiating pain to both lower extremities. A CT myelogram would be indicated provided the patient meets specific criteria to include specific findings of a cerebral spinal fluid leak, the need for surgical planning, radiation therapy planning, diagnostic evaluation of a spinal or basilar cisternal disease, or infection involving the bony spine, poor correlation of physical findings with MRI studies, or an MRI is precluded secondary to significant findings. The patient is noted to have specific complaints of hyporeflexia in the lower extremities specifically on the left. The left knee is noted to have diminished reflexes and the left ankle is noted to have an absent reflex. Given these specific findings, this request is reasonable. As such, it is the opinion of this reviewer that the request for a CT myelogram of the lumbar spine is recommended as medically necessary.

IRO REVIEWER REPORT TEMPLATE -WC

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

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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. (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