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Notice of Independent Review Decision

Date: November 11, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CT myelogram lumbar spine

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

Diplomate American Board of Orthopaedic Surgery
Fellowship Trained Spine Surgeon

REVIEW OUTCOME:

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

Overturned (Disagree)

Medical documentation supports the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Utilization reviews (08/06/13, 10/10/13)
- Operative report (04/09/13)
- Diagnostic (04/09/13 – 04/30/13)
- Office visits (04/22/13 - 07/25/13)
- Physical therapy evaluation (05/14/13)

ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained injury to his low back on xx/xx/xx, when his chair broke and he fell.

On April 9, 2013 an orthopedic surgeon, evaluated the patient for significant radiculopathy and back pain. The patient was noted to have previous

laminectomy with a work and industrial injury. The patient had spondylolisthesis at L5-S1 and post-laminectomy syndrome with foraminal stenosis at L5-S1. performed pedicle screw instrumentation at L4-L5, open reduction of spondylolisthesis at the L5-S1 level, revision laminectomy at L5 with decompression of both the foraminal regions, revision of scar, placement of AmnioShield and adhesive barrier overlying the excised dura, posterolateral fusion at L5-S1 bilaterally and bone marrow aspiration from the left posterior iliac spine. The patient also underwent full radical discectomy at L5-S1 with partial corpectomy on the inferior aspect of the L5 and superior aspect of S1; placement of prosthetic cage at the L5-S1 level with screws in the vertebral body of S1 and interbody fusion at L5-S1. The postoperative diagnosis was spondylolisthesis at L5-S1, foraminal stenosis at L5-S1, prior laminectomy syndrome at L5-S1 and postlaminectomy syndrome with significant foraminal stenosis at L5-S1.

On April 22, 2013 saw the patient for first postoperative follow-up visit. The patient was two weeks status post anterior lumbar interbody fusion (ALIF) at L5-S1. The patient reported having a significant amount of back and leg pain. He stated that it was a different pain. Prior to surgery, he was on high dose of Dilaudid. He had resumed his Dilaudid medications with Examination of the lumbar spine showed well-healed surgical scars. X-rays of the lumbar spine showed good placement interbody fusion graft and posterior pedicle screws at L5-S1 and no change in intraoperative alignment. Ms. diagnosed lumbosacral neuritis or radiculitis, unspecified; acquired spondylolisthesis and low back pain. She prescribed Decadron and recommended starting physical therapy (PT) to address strengthening and conditioning of the lumbar spine.

On April 30, 2013, noted that the incisions were healing well. He re-evaluated the x-rays of the lumbar spine that looked appropriate and improved from the preoperative status. The patient's ambulation was also improved. However, he did have poor pain control. The patient was walking with a cane. diagnosed spondylolisthesis with maintained alignment, overall improved. He recommended re-evaluation in four weeks.

On May 14, 2013, the patient underwent a PT evaluation and was recommended PT three times a week for six weeks.

On May 20, 2013 noted that the patient was overall improving. The patient was on Dilaudid for about a year prior. He was presently on Percocet. He rated his pain at about 7/10. His leg symptoms were about 6. He had decreased spasms. He was able to walk better. obtained x-rays of the lumbar spine that showed significant improvement; the screw appeared to be in satisfactory position at the L5-S1 level. He scheduled the patient for PT and recommended considering some aquatic therapy and continuing off work status.

On July 1, 2013, recommended continuing PT to include lumbar stabilization exercises. He gave a nutrition handout.

On July 25, 2013, evaluated the patient for back pain. The patient stated that he fell at home three days ago. He stated that his right leg was nine days out on him. He fell against his wife's car. He had x-rays of the chest that showed a possible right rib fracture. He had not had any other change or increase in his back pain. The right leg was giving out on him more. X-rays of the lumbar spine showed no changes, no fracture of the hardware and no lucency or halo ring screws. Ms. diagnosed four months status post 360 degrees ALIF L5-S1 with continued right leg pain and numbness. She ordered a computerized tomography (CT) myelogram of the lumbar spine per recommendation that would allow evaluating any further stenosis especially at the L4-L5 level which the patient had changes prior to the surgery. The patient would talk to his pulmonologist about the CT of the chest.

Per utilization review dated August 6, 2013, the request for lumbar CT myelogram was denied based on the following rationale: *"The claimant is a male, who reported sustaining a work-related injury to the low back on xx/xx/xx. The medical records provided do not denote the mechanism of injury. The claimant was diagnosed with acquired spondylolisthesis. The claimant is status post lumbar fusion at L5-S1 on April 9, 2013. Per the provided x-rays obtained in the office on July 22, 2013, reported no changes. There was no fracture of the hardware. There were no lucency or halo ring screws. The claimant has undergone PT; however, the dates and frequency and duration were not specified. On evaluation by the requesting physician on July 22, 2013, the claimant reported he fell at home three days prior when the right leg gave-out. X-rays of the chest was obtained, which showed a possible rib fracture. There were no other changes noted, with no increase in back pain noted. The recommendation was for a CT myelogram of the lumbar spine to evaluate any further stenosis at the L4-L5 level. The guidelines state that CT myelogram is indicated for demonstration of cerebrospinal fluid leak, surgical planning, or poor correlation of physical findings with magnetic resonance imaging (MRI) studies. There is no documentation of any surgical planning. The x-rays of the lumbar spine reported the hardware was intact. Based upon the medical documentation provided for review and the peer-reviewed, evidence-based guidelines, the request is noted medically supported. The request for CT myelogram is not certified."*

Per reconsideration review dated October 10, 2013, the appeal for reconsideration of lumbar CT myelogram was denied based on the following rationale: *"The patient is a male who sustained an injury on xx/xx/xx, when his chair broke and he fell. The patient is diagnosed with lumbar spinal stenosis and lumbosacral neuritis or radiculitis status post surgery. An appeal request is made for lumbar CT myelogram. The previous request was denied because there is no documentation for any surgical planning. Also, the x-rays of the lumbar spine reported the hardware was intact. The updated medicals include a PT note dated September 13, 2013. The patient underwent 360 degrees lumbar fusion of L5-S1 on April 9, 2013. Postoperatively, the patient has had PT. X-rays of the lumbar spine dated July 25, 2013, revealed no changes, no fractures of the hardware and no lucency or halo ring screws. The medical report dated July 25, 2013, states that the patient has persistent back pain. It was noted that the patient fell at home*

three days ago. His right leg gave out. There is continued right leg pain and numbness. It was noted that a CT myelogram of the lumbar spine is recommended to evaluate any further stenosis at the L4-L5 level. The PT note dated September 13, 2013, states that the patient has lumbar spine. On physical examination, there is minimal tenderness in the lumbar paraspinal muscles. There is decreased lumbar range of motion (ROM). There is decreased strength in the lower extremities. There is decreased cadence and moderately antalgic gait. The current guidelines optionally advocate the use of these studies only if surgical planning is warranted. However, there is still no indication for plans for surgery. Also, there is no indication that the patient has cerebrospinal fluid leak or spinal or basal cisternal disease, infection involving the bony spine, intervertebral discs, meninges and surrounding soft tissues, or inflammation of the arachnoid membrane that covers the spinal cord to warrant the diagnostic study. In agreement with the previous determination, the medical necessity of the request has not been established."

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

The records forwarded for review included the April 9, 2013, operative report as well as follow-up visits from April 22, 2013, through July 25, 2013. There was also a physical therapy evaluation of May 14, 2013, as well as utilization review denials.

had evaluated the patient who was noted to have had a low back injury on xx/xx/xx, when his chair broke and he fell. On April 9, 2013, performed an anterior posterior fusion surgery doing an anterior approach with the access surgeon, and then the posterior surgery was done. The anterior surgery was radical discectomy at L5-S1 with placement of the prosthetic cage at L5-S1 and interbody fusion at L5-S1. The posterior procedure was that of pedicle screw instrumentation at L4 and L5 and over-reduction of the spondylolisthesis of L5-S1. Posterolateral fusion was performed at L5-S1 bilaterally.

Postoperatively, the patient had significant residual back pain on his initial office visit of April 22, 2013. The patient had been put back on his Dilaudid medication by his pain management doctor. The patient's pain diagram showed pain symptoms of burning and ache into both lower extremities. The patient considered his symptoms to be worse than previous.

The patient was given a Decadron taper and was to start on a home exercise program.

On April 30, 2013, noted the patient was walking a cane. The patient had x-rays taken showing the instrumentation to be adequate with improved alignment of the L5-S1 spondylolisthesis.

A therapy assessment was completed on May 14, 2013, which indicated that the patient had marked limitations of straight leg raise bilaterally. The patient had

increased sensitivity to touch over the lumbosacral scar and lumbar area as well as to light touch in the right lower extremity. The patient was considered to have bilateral positive straight leg raise per the therapist.

On May 20, 2013, the patient's symptoms were approximately the same. The patient was now on Percocet. The patient was going to do aquatic therapy.

Repeat x-rays taken May 20, 2013, showed the pedicle screws to be satisfactory at the lower lumbar segment.

On July 1, 2013, the patient's pain level was still listed as 6/10 scale with 5/10 scale for the leg pain; the pain diagram shows primarily right lower extremity findings with stabbing pain as well as back pain from the thoracolumbar junction to the right buttock.

The patient on July 25, 2013, reported that his leg had given out on the right side and he had fallen. He had a possible rib fracture when he fell against his large car when that leg gave way. He was to see a pulmonologist. The right leg was reported to be giving out more. proposed a CT myelogram of the lumbar spine.

This request was reviewed by two utilization review physicians, a physiatrist and fellowship trained spine surgeon respectively. The request for myelogram CT scan was denied.

The patient is now status post two level spine fusion with significant residual pain and dysfunction into the lower extremities, right more than left. The patient had a reduction procedure performed of L5 on S1 for the spondylolisthesis per the operative report. The patient has fallen and recently had a possible rib fracture. The proposed imaging studies would be warranted to rule out that there is any entrapment or pressure on the nerve roots that go the right lower extremity from the L4-L5 and L5-S1 level to make certain that there is no physiological entrapment in the spine as the basis for the patient's weakness and giving out of the right lower extremity. The examination of this patient appears to be compromised due to increased pain symptoms as documented by the physical therapist. Thus the objective imaging study appears to be medically necessary to fully evaluate this patient's lumbar spine neurological and bony anatomy. Thus, the request is approved as a medical necessity.

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