Icon Medical Solutions, Inc.

11815 CR 452
Lindale, TX 75771
P 903.749.4272
F 888.663.6614

Notice of Independent Review Decision

DATE: October 14, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar CT/Myelogram

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is certified by the American Board of Orthopaedic Surgery with over 42 years of experience.

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 <u>each</u> of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
05/11/12: MRI Lumbar Spine without Contrast report
11/29/12: Designated Doctor Evaluation
01/22/13: FCE (no physician listed)
02/01/13: Operative Report
02/01/13: Radiography Note
02/07/13, 02/21/13, 05/09/13, 06/20/13, 08/08/13: Office Visit
03/04/13: MRI Lumbar Spine without Contrast report interpreted
04/23/13: Designated Doctor Evaluation
04/24/13: Operative Report
04/24/13: Radiology Report
07/19/13: MRI of the Lumbar Spine without and with Contrast report Imaging
08/15/13: Office Visit
08/28/13: Office Visit
08/28/13: UR performed
09/23/13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who was injured at work on xx/xx/xx. He is status post ESI, physical therapy, and lumbar laminectomy at L2-L3.

05/11/12: MRI Lumbar Spine without Contrast report. IMPRESSION: Lumbar spine chronic degenerative changes with L2-L3 through L5-S1 intervertebral disc bulges/herniation producing central spinal stenosis (most marked at the L2-L3 level) and varying degrees of neural exit canal impingement bilaterally. Please see individual level detailed descriptions above. Lumbar spine chronic degenerative changes have increased since the previous study of 12/04/06. Surgical consultation is recommended. The patient may benefit from epidural steroid pain management injections, especially if he is not a surgical candidate or if surgery is currently not considered an option.

02/01/13: Operative Report. POSTOPERATIVE DIAGNOSIS: Low back pain. Lumbar disc disease with bilateral lumbar radicular syndrome in the L2-L3 distribution. PROCEDURE: Bilateral L2 transforaminal epidural steroid injection at the L2-L3 level.

02/07/13: The claimant was evaluated. He reported no relief with spinal injection. He complained of low back pain and left thigh pain. He stated that Ultram was not effective for him. Strength was 5/5 in the bilateral lower extremities including iliopsoas, quadriceps, hamstrings, gastrocnemius and soleus, EHL, and anterior tibialis. No assistive aids. No clonus. It was noted that he had thigh pain consistent with the upper lumbar disc herniation such as the one noted at L2-L3. It was noted that he may be a candidate for lumbar discectomy surgery since the injection was not working. He was given hydrocodone for pain.

02/21/13: The claimant was evaluated. He had 5/5 strength in the lower extremities. No hyperreflexia or clonus. Antalgic gait favoring the left leg.

03/04/13: MRI Lumbar Spine without Contrast report. FINDINGS: L2-L3: Moderate disc height and signal loss is present with a mild broad-based disc bulge with mild bilateral facet arthropathy and ligamentum flavum hypertrophy causing mild bilateral lateral recess stenosis and mild bilateral foraminal stenosis. Mild central stenosis is present. L3-L4: Mild disc height and signal loss is present with a mild broad-based disc bulge with mild bilateral facet arthropathy and ligament flavum hypertrophy with mild-moderate right and mild-moderate left foraminal stenosis. Mild central canal stenosis is present. L4-L5: moderate disc height and signal loss is present with a small moderate broad-based disc bulge with small central disc protrusion with mild bilateral lateral recess stenosis. Mild bilateral facet arthropathy and ligamentum flavum hypertrophy are present. Moderate right and mild-moderate left foraminal stenosis identified. Tiny left frontal posterior annular tear is seen. L5-S1: Moderate-severe disc height and signal loss is present with a mild broad-based disc bulge and tiny superimposed central disc protrusion. Mild bilateral frontal stenosis is noted.

04/24/13: Operative report. POSTOPERATIVE DIAGNOSIS: L2-L3 disc herniation. Lumbar radicular syndrome. PROCEDURE: L2 partial laminectomy. L3 partial laminectomy. Nerve root monitoring. Application of dural graft.

05/09/13: The claimant was evaluated for low back pain at the incision site with improved leg pain. He had 5/5 strength in the upper and lower extremities bilaterally. No hyperreflexia. No clonus. The incision was dry and intact. He was to start physical therapy. He was given Norco, Flexeril, and Nystatin.

06/20/13: The claimant was evaluated for low back pain and left leg pain. He noted increased pain from surgery. On exam, he had 5/5 strength in the upper and lower extremities. No hyperreflexia. No clonus. He was to obtain an MRI scan.

07/19/13: MRI Lumbar Spine without and with Contrast report. IMPRESSION: L2-L3 severe central spinal stenosis due to intervertebral disc herniation seen on the previous study of 05/11/12 status post surgery/partial discectomy with moderate central spinal stenosis and moderate impingement of the neural exit canals bilaterally on the current study.

08/08/13: The claimant was evaluated for low back pain and bilateral hip pain. On exam, he had 5/5 strength in the bilateral upper and lower extremities. No hyperreflexia. No assistive aids. He was to be referred for consideration of spinal cord stimulator for revision L2-L3 surgery with stabilization if indicated. He was given a prescription for Norco 10/325 mg #100.

08/15/13: The claimant was evaluated for back and bilateral leg pain. He reported ongoing low back pain radiating down both legs, primarily in the sciatic nerve distribution. His leg symptoms were worse with standing and walking and improved by sitting or lying down, consistent with neurogenic claudication. On exam, his gait was balanced. Paravertebral muscles were nontender with no evidence of spasm or trigger point. Lumbar range of motion was normal in all directions and non-painful. SLR normal bilaterally with no issues. Femoral stretch negative bilaterally. Lower extremity strength was symmetrically present in all lower extremity muscle groups. Reflexes were symmetrically present and normal. AP, lateral, and flexion/extension views of the lumbar spine dated 01/11/13 were reviewed. They were negative. No spondylolisthesis or other deformity. MRI of the lumbar spine dated 07/19/13 demonstrated post-surgical changes at L2-L3. Congenitally narrow spinal canal throughout the lumbar region with degenerative facet hypertrophy and disc degeneration contributing to mild-moderate lateral recess stenosis bilaterally at L3-L4 and L4-L5 primarily. Successful decompression at L2-L3. ASSESSMENT: Persistent back and bilateral leg pain consistent with neurogenic claudication despite L2-L3 decompression in April 2013. Normal neurological exam. Congenital and degenerative stenosis, primarily at L3-L4 and L4-L5. No gross instability. PLAN: He would benefit from additional decompression at L3-L4 and L4-L5, possibly

more. Suggest lumbar CT myelogram to get as much information as possible about his stenosis. Not an appropriate candidate for spinal cord stimulator at this time.

08/28/13: The claimant was evaluated for possibility of spinal cord stimulator. PLAN: I agree about the CT myelogram first. If he is not a surgical candidate after those evaluations, then the spinal cord stimulator may be a viable option.

08/28/13: UR Performed. COMMENTS: Official Disability Guidelines recommend a myelogram or CT myelogram for surgical planning, especially with regards to nerve roots, as a myelogram can show whether surgical treatment is promising in a given case and, if so, can help in surgical planning or when there is poor correlation with physical findings with the MRI studies. However,, as the patient is not noted to have any abnormal neurological findings on physical exam that correlate with the findings on the MRI and the physician opined that he felt that the patient had a successful decompression t L2-L3, the need for a CT myelogram is not established.

09/23/13: UR performed. COMMENTS: CT myelogram was requested to get as much information as possible about his stenosis. Updated documentation included a recent report dated 08/28/13. The patient presented with persistent low back pain with neuropathic claudication in the legs. The patient was utilizing Flexeril and Norco. Examination was relatively unchanged since the previous evaluation. CT myelogram was again recommended. Plans to proceed with spinal cord stimulation if he was not established to be a surgical candidate were noted. However, the current examination did not reflect any neurological compromise warranting consideration of operative intervention and subsequent surgical planning. With the above issue, the medical necessity of this request remains unsubstantiated.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse determinations are overturned. This case meets the ODG criteria for surgical planning. In cases of spinal stenosis, there are usually no positive neurological findings, and the diagnosis is usually made with a positive history of neurogenic claudication along with MRI and especially with myelography and CT. The levels involved, as well as the severity, can be determined with CT/Myelography in planning surgery. Therefore, the request for Lumbar CT/Myelogram is medically necessary.

ODG:

CT (computed tomography)	**<u>Indications for imaging</u> -- 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)
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

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)**