

Notice of Independent Review Decision

April 16, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Medical Necessity: Lumbar Myelogram with CT 62284 72132

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

The physician performing this review is Board Certified, American Board of Orthopedic Surgery. The physician has been in practice since 1998 and is licensed in Texas, Oklahoma, Minnesota and South Dakota.

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)

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

Upon independent review, I find the previous adverse determination should be overturned.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records Received: 19 page fax 03/27/13 Texas Department of Insurance IRO request, 53 pages of documents received via fax on 03/28/13 URA response to LHL602 REV 01/13

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disputed services including administrative and medical. 38 pages of documents received via fax on 03/29/13 Provider response to disputed services including administrative and medical. Dates of documents range from xx/xx/xx(DOI) to xx/xx/xx.

PATIENT CLINICAL HISTORY [SUMMARY]:

Mr. is a now male with a previous work-related injury that led to a surgical procedure. The most recent records would indicate the patient continues to suffer from severe low back pain with pain radiating into the leg. There are bilateral findings of diminished sensation in the L5 distribution as well as weakness of dorsiflexion of both the ankles and great toes and a positive straight leg raise test bilaterally. The patient has reportedly failed a rather lengthy period of pain management and requires daily narcotic medications for pain control and continues to be incapacitated, according to the medical records.

While the treating physician's documentation points to a very obvious L5 radiculopathy bilaterally, the most recent imaging study performed in August of 2012 fails, at least in my mind, to reveal any evidence of a cause for an L5 radiculopathy. The simple finding of "mild" foraminal stenosis at the L4-5 level is not likely to be a cause of a profound L5 radiculopathy. Since the clinical findings and the MRI do not appear to correlate, it is felt that *ODG* guidelines allow for the requested procedure.

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

An MRI evaluation performed in August of 2012 reveals only mild bilateral neural foraminal narrowing at the L4-5 level. There is no definitive evidence for particular nerve root impingement. Comparing this to the clinical exam findings present in the treating physician's notes that indicate an obvious L5 radiculopathy demonstrated by both sensory and motor deficits corresponding to that nerve root level, it would appear that these MRI imaging studies do not correlate with the physical examination findings, and as such, *ODG* guidelines allow for myelography with CT scan under these circumstances

ODG -TWC

ODG Treatment

Integrated Treatment/Disability Duration Guidelines

Low Back - Lumbar & Thoracic (Acute & Chronic)

[Back to ODG - TWC Index](#)

Myelography	Not recommended except for selected indications below, when MR imaging cannot
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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)**