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Notice of Independent Review Decision

DATE: January 28, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Myelogram with Post-Myelogram CT

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 Surgeons with 42 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 medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

10/05/11: Office Visit by, MD
10/11/11: MRI Lumbar Spine without Contrast report interpreted by MD with OPC
11/30/11: Surgical Consultation by MD with The Group
12/22/11, 01/03/12: Office Visit/Procedure Note by MD
02/01/12, 07/10/12, 11/14/12, 12/13/12: Followup visit by MD
07/23/12: UR performed by MD
07/27/12: Letter of Medical Necessity by MD
12/19/12: Peer-to-Peer Notes by MD
12/20/12: UR performed by MD

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who injured his low back at work while repeatedly lifting metal grates, metal angle irons, and wooden plates on xx/xx/xx.

10/11/11: MRI of the Lumbar Spine without Contrast report interpreted by MD. IMPRESSION: Mild broad-based disc protrusion at the L3-L4 disc level producing mild acquired spinal stenosis. Broad-based disc protrusion t the L4-L5 disc level producing mild acquired spinal stenosis and mild bilateral neural foraminal stenosis, left greater than right. Large left central/foraminal disc protrusion at the L5-S1 disc level producing mild acquired spinal stenosis with moderate to severe left neural foraminal stenosis.

11/30/11: The claimant was evaluated by MD for low back pain radiating into the left paravertebral region and down the back of the leg. He felt the pain all the way to the calf and ankle at times. Sitting, standing, and walking made the pain worse. He said that the pain was made worse by bending forward. He felt some numbness in the left leg. On physical exam, he had a slow gait and favored the left leg more than the right. Examination of the back revealed tenderness between L4 and the sacrum as well as discomfort in the left sciatic notch. There was some discomfort in both paravertebral regions with spasms bilaterally. Forward bending caused pain at 45 degrees. Lateral bending and tilt caused pain in both directions. Extension caused no pain. He had good strength on the right. On the left, there was slight weakness of plantar flexion on the left compared to the right. DTRs were +1 at the knees and right ankle. Ankle jerk was diminished on the left. SLR caused pain at 45 degrees on the left and negative at 60 degrees on the right. Review of MRI showed a large left central herniation at L5-S1 and broad-based disc protrusion that was worse on the left at L4-L5. There was a bulging disc at L3-L4. Dr. noted that the worst level appeared to be at L5-S1. His recommendations were to proceed with a trial of heat therapy and get an EMG nerve conduction study of the left leg. He was going to start him on exercise therapy and do transforaminal injections at L4-L5 and L5-S1 on the left.

12/22/11: The claimant was evaluated by MD for low back and left leg pain after lifting metal beams and crates at work. He noticed some numbness and tingling with his pain. He stated that he would do anything to avoid surgery. He was noted to have pain in the back when bearing down. He had decreased exercise tolerance. He was noted to have erectile dysfunction. It was noted that after becoming erect, he was unable to feel his penis during intercourse and ejaculated without knowing he did it. He was also noted to have bladder and urinary tract dysfunction. On physical exam, his gait was normal. He had normal sensation and motor testing of the lower extremities. Straight leg raised was positive bilaterally. Lumbar range of motion was decreased with pain. He had lower thoracic to sacral tenderness on palpation along the midline. He had lumbar muscle spasm. PLAN: Avoid cigarette smoke. Conditioning program. Increase activity. Schedule fluoroscopic procedure.

01/03/12: Procedure Note by MD. PROCEDURE: Transforaminal Epidural Steroid Injections at Left L4-L5 and Left L5-S1. IMPRESSION: Mr. has acute low back pain and left lumbar radiculopathy that has not responded adequately to primary care. The patient has multilevel lumbar disc disease at L3-L4, L4-L5, and L5-S1. Based on his symptoms, I am treating him today with transforaminal

epidural steroid injections at left L4-L5 and left L5-S1. Continue his current medications and activity. Depending upon his response, I will consider treatment at the L3-L4 level. Reevaluation in about three weeks.

02/01/12: The claimant was reevaluated by MD. He stated that he started having pain going down the right buttock and down the back of the right thigh and back of the right leg. He stated that he had a blood clot over the anterior right thigh that went away and the next day had a bruise. Then, he noticed that his right knee was a little puffy and was now numb. On physical exam, he had midline tenderness and bilateral paravertebral spasm with tenderness. Sciatic notch discomfort was present on the left and absent on the right. No pain on palpation of either butt cheeks. He could stand on his toes and heels. Motor exam was normal. SLR was positive at 60 degrees bilaterally. Dr. was going to request EMGs of both lower extremities.

07/10/12: The claimant was reevaluated by MD for increasing pain in his back and leg. On physical exam, he was 5' 10" and weighed 251 pounds. He had midline tenderness. He had tenderness over the left paravertebral region with spasm. Sciatic notch discomfort was present on the left and absent on the right. He could stand on his toes and heels. Motor exam was normal. SLR was positive at 60 degrees bilaterally. The EMG of the left lower extremity was noted to be normal. Dr. wanted to order a lumbar myelogram and post-myelogram CT scan since he was continuing to have problems despite conservative treatment. He was given prescriptions for Neurontin, Lortab 5 mg, and Zanaflex 4 mg. He was to remain off work.

07/23/12: UR performed by MD. RATIONALE: The guidelines indicate that myelography is not recommended unless documentation of contraindications to MRI are noted. Repeat diagnostic imaging is not indicated unless documentation of progressive neurological deficit is noted on physical examination or significant changes in subjective complaints are noted. Without any surgical planning noted, radiation therapy planning noted, suspected cerebral spinal fluid leak noted, and without changes in physical examination findings or contraindications to MRI, the request is not clinically warranted.

07/27/12: Letter of Medical Necessity by, MD. "The patient underwent an MRI on October 11, 2011. At that time, the impression of the MRI was a broad-based disc protrusion at L3-L4 producing mild spinal stenosis. At L4-L5, there was a broad-based disc bulge producing mild stenosis with bilateral foraminal stenosis, left greater than right, and a large disc herniation to the left at L5-S1 with severe foraminal stenosis. At this point, I would like to further evaluate what effect weight-bearing has. I would like to see which of the nerves is causing the patient his symptoms. I would like to really narrow down the problem. That was the reason I was requesting a myelogram. I feel surgery will ultimately have to be done, but I did not want to operate on three levels. Dr. is a Board-Certified Orthopedist. I am a Neurosurgeon. I feel myelography is better suited to look at the nerve roots."

11/14/12: The claimant was evaluated by MD for continued low back pain and pain going down the side of the left leg and occasionally the right leg. It was noted that they "got a letter from Workman's Comp stating that he had previously been into pain management where he was initially seen in 2011. He did not mention this also. When he had some drug test in December 2011, it was negative for opioids as per the patient's assertion he was taking his pain medication per the case manager. He said that he was getting medications in Texas, however, I told him that there was a problem if did not have any opioids in his system that he was getting it." It was noted that he said he had no numbness or tingling or any weakness in either leg. On physical exam, he had some midline tenderness. He had slight paravertebral spasm. Sciatic notch discomfort was present on the left. He could stand on his toes and heels. Motor exam was normal. SLR was positive at 60 degrees bilaterally. Reflexes were symmetrical. It was noted that they "would get him into pain management evaluation and treatment. I told him today that I will not get him any more medication due to the fact that he tested negative for opioids and he did not tell us that he had been to a pain physician."

12/13/12: The claimant was reevaluated by, MD for pain in his back and down the side and back of the left leg and occasionally the right. On physical exam, he had midline tenderness and bilateral paravertebral spasm, worse on the left than the right. Sciatic notch discomfort was present bilaterally. He could stand on his toes and heels. Motor exam was normal. SLR was positive at 60 degrees bilaterally. Reflexes were symmetrical. It was noted that Dr. was still waiting on the approval of the lumbar myelogram and post-myelogram CT. The claimant was to remain out of work.

12/19/12: Dr. noted that a peer-to-peer discussion was made with Dr.. It was noted that they discussed the claimants fluctuating neurological findings noting that when he was first seen, he did have some weakness of plantar flexion with a diminished ankle reflex, which had varied since his examination. Dr. felt that it was due to the epidural injections as well as pain management to some degree. It was noted that he had a disc protrusion at L4-L5 as well as L5-S1 and myelogram was recommended. It was noted that the peer-to-peer doctor wanted an updated exam and "he was actually seen on December 13th."

12/20/12: UR performed by MD. RATIONALE: ODG criteria for CT myelography includes MRI unavailable, contraindicated, or inconclusive, or CT myelogram used as supplement when visualization of neural structures is required for surgical planning or other specific problem solving. There is documentation of a previous adverse determination for lack of surgical planning and lack of changes in physical exam or contraindications to MRI. The supplemental report identifies that the patient underwent an MRI on 10/11/11 demonstrating at L3-L4 a broad-based disc protrusion producing mild spinal stenosis, at L4-L5 a broad-based disc bulging producing mild stenosis with bilateral foraminal stenosis, and at L4-L5, a large disc herniation to the left with severe foraminal stenosis. At this point, the

requesting provider would like to further evaluate what affect the weight-bearing has and would like to see which of the nerves are causing the patient's symptoms. Discussion identifies that myelography is better suited to look at the nerve roots than MRI. However, there remains no evidence of a specific surgical treatment plan or how a myelogram would alter the treatment plan.

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

The previous adverse decisions are upheld. I agree with Drs. and. There is no contraindication for an MRI, no inconclusive MRI findings, and no indication of worsening of his neurological exam. His neurological exam on 12/13/12 notes normal motor exam, symmetrical reflexes, and straight leg raising positive at 60 degrees bilaterally. Therefore, the request for Lumbar Myelogram with Post-Myelogram CT is not medically necessary and is non-certified.

ODG:

<p>Myelography</p>	<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> <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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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)**