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Notice of Independent Review Decision

Date notice sent to all parties: 6/18/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

lumbar myelogram with CT scan, CPT codes 72132 and 62284

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

Texas Licensed Board Eligible Neurosurgeon

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. 6/3/13 IRO request form
2. 5/22/13 and 5/15/13 Denial letters and rationale
3. 5/14/13 Preauthorization request
4. 5/9/13 letter to
5. 6/27/12 MR L Spine W WO findings
6. 2/12/13 CT Lumbar Spine W/O contrast; findings
7. 9/12/12 Accident & Injury Rehab notes
8. 2/12/13 Lumbar Spine w/ Bending Views report

PATIENT CLINICAL HISTORY [SUMMARY]:

Record review indicates that the patient is a female injured on xx/xx/xx, and again on xx/xx/xx. No further information is available about her first injury on xx/xx/xx. On xx/xx/xx, her second injury was while working at. She was lifting and experienced immediate onset of severe low back pain, bilateral hip and leg pain. She quit work in 2012 because of this pain and the associated numbness, dysesthesia, and weakness worse on the right than on the left. She feels that her pain has been getting worse. She has had chiropractic care of uncertain duration. There are no chiropractic notes available for review other than an initial evaluation. She had physical therapy of unknown type or duration. There is no physical therapy note included for the review and some type of chronic pain management that apparently did not include any type of injection. No pain management notes are included for review. She is currently taking hydrocodone and ibuprofen. There is vague reference in the notes that she has taken other medications in the past. She has had a psychological evaluation; no results were given. She has had a surgery requested in the past that was denied. She states that her pain is aggravated by walking, standing, and other activity.

PAST MEDICAL HISTORY:

She has a past medical history of colitis, cholecystitis, appendicitis, previous disc rupture at age 15, and hypertension.

PAST SURGICAL HISTORY:

She has a past surgical history which includes cholecystectomy, a discectomy at age 15 with full recovery.

FAMILY HISTORY:

Negative for significant disease.

SOCIAL HISTORY:

Patient is currently not working secondary to pain related to the above injury. She does not smoke. She does not use alcohol.

ALLERGIES:

She has no known drug allergies.

MEDICATIONS:

Her only medications are hydrocodone and Motrin.

did an exam on 05/09/2013 and states that the patient walks with slightly flexed posture, has paraspinal muscle tightness, loss of lordosis with sciatic tenderness to palpation worse on the right and antalgic gait. Positive right leg raise at 45 degrees. Positive left leg raise 50 degrees. Decreased sensation bilateral in the L5-S1 dermatomes. Has difficulty with toe standing or heel standing more notable on the right than on the left and difficulty getting up off of the exam table and getting into a chair. There were no notable differences on his exam in reflexes from right to left. No muscle wasting. No muscle fasciculations. No pathological reflexes. There was also no grading of muscle strength or notation of any particular weakness in any muscle group except for what he notes difficulty with heel standing, toe standing, or getting up off of the table. There is another exam reviewed, appears to be a doctor chiropractic on 05/22/2012, which showed no muscle weakness at that time. No loss of sensation at that time. Normal reflexes. Decreased range of motion of the lumbar spine only. Patient did have MRI scan performed on 06/27/2012, with the following findings. Degenerative changes of the lumbar spine most significantly at the L3-4 and L4-5 level and at L4-5 level, there was a large circumferential and diffuse disc protrusion resulting in compression of the thecal sac and spinal canal narrowing as well as lateral recess stenosis. There are no segmental disc protrusions. She also had plain films done on 02/12/2013 with flexion/extension views that shows a grade-I anterolisthesis of L5 on S1 with minimal anterolisthesis of L4 on L5, significant loss of disc height at L4-L5. No evidence of acute fracture of the lumbar spine by plain radiography and the vertebral body heights appeared normal. There was facet arthropathy seen at L4-L5 and L5-S1. She also had a CT scan done of the lumbar spine on 02/12/2013, which showed degenerative disc disease in the lower lumbar spine most pronounced at L4-L5. Minimal anterolisthesis of L4 on L5 measuring only a few millimeters. No evidence of acute or chronic fracture, mild disc bulges are noted at multiple levels, no significant canal stenosis appreciated by CT scan. There was mild to moderate neural foraminal stenosis at L4-L5 which is slightly more pronounced on the right.

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

The treating surgeon is requesting a CT myelogram. The ODG criteria 18th edition Workers' Comp 2013 update citation states that the CT scan is not indicated except for some indication (Slebus, 1998) (Bigos, 1999) (ACR, 2000) and (Airaksinen, 2006) (Chou, 2007). Magnetic resonance imaging has largely replaced computed tomography scanning in the noninvasive evaluation of patients with painful myelopathy because of superior soft tissue resolution and multiplanar capability. This is Seidenwurm 2000. The new ACP/APS guideline as compared to the old AHCPR guideline is more forceful about the need to avoid specialized diagnostic imaging such as computed tomography without a clear rationale for doing so (Shekelle, 2008). A new meta-analysis of randomized trials finds no benefit to routine lumbar imaging (radiography, MRI or CT) for low back pain

without the indications of serious underlying conditions, and recommendation that clinicians should refrain from routine, immediate lumbar imaging in these patients (Chou-Lancet, 2009). Primary care physicians are making a significant amount of inappropriate referrals for CT and MRI according to new research published in the Journal of American College of Radiology. There were high rates of inappropriate examinations for spinal CTs (53%), and for spinal MRIs (35%) including lumbar spine MRI for acute back pain without conservative therapy (Lehnert, 2010). For suspected spine trauma, i.e. fractures, lumbar or cervical, thin-section CT examination with multiplanar reconstructed images may be recommended. Image software postprocessing capabilities of CT including multiplanar reconstructions and 3-dimensional display further enhances the value of CT imaging for reconstructive trauma surgeons.

INDICATIONS FOR IMAGING:

CT scan:

Thoracic spine trauma: equivocal or positive plain films and no neurological deficit.

Thoracic spine trauma: with neurological deficit.

Lumbar spine trauma: trauma with neurological deficit.

Lumbar spine trauma: such as seat-belt injury for soft fracture.

Myelopathy, neurologic deficit related to the spinal cord (traumatic): traumatic.

Myelopathy, infectious disease in the patient.

Evaluation of a pars defect not identified on plain x-ray.

Evaluation of successful fusion if plain x-rays do not confirm fusion.

Myelography is not recommended except for selected indications below, when MR imaging cannot be performed or in addition to MRI. Myelography and CT myelography is okay if MRI unavailable or contraindicated presence of a foreign body or inconclusive. Invasive evaluation by means of myelography and CT myelography may be supplemental when visualization of neural structures is required for surgical planning or other specific problem solving. Myelography and CT myelography have largely been superseded by the development of high resolution CT and magnetic resonance imaging, but there remain the selected indications below for these procedures, when MR imaging cannot be performed or in addition to the MRI.

ODG criteria for myelography and CT myelography:

Demonstration of the site of a cerebrospinal fluid leak be it postlumbar puncture headache or postspinal surgery headache, rhinorrhea, or otorrhea.

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.

Radiation therapy planning for tumors involving the bony spine, meninges, nerve roots or spinal cord.

Diagnostic imaging 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.

Poor correlation of physical findings with MRI studies.

Use of MRI precluded because of claustrophobia, technical issues, safety reasons or surgical hardware.

Given the ODG criteria, the patient's exam, the MRI scan and CT scan, which was just done few months ago, plain film that showed no movement of flexion/extension films, there is no indication for a myelogram or CT myelogram of this patient at this time.

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): The following were used, as cited in the analysis: (Slebus, 1998) (Bigos, 1999) (ACR, 2000) (Airaksinen, 2006) (Chou, 2007) (Seidenwurm 2000) (Shekelle 2008) (Chou-Lancet, 2009) and (Lehnert, 2010)