

Health Decisions, Inc.

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Notice of Independent Review Decision

[Date notice sent to all parties]: July 15, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient Lumbar Myelogram 62284

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

This physician is a Board Certified Neurosurgeon with over 16 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:

09-09-12: ER Report
09-11-12: CT Lumbar Spine
10-09-12: Chart Note
10-29-12: MRI Lumbar Spine
11-07-12: Chart Note
11-16-12: Chart Note
12-05-12: Chart Note
12-17-12: Evaluation
01-09-13: Operative Report
05-09-13: Evaluation
05-17-13: UR performed
06-06-13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured at work on xx/xx/xx. He was unloading some sacks and he had turned to set one down and when he turned back around,

someone had already pitched another sack off the trailer and he wasn't ready to catch it and reported that it hurt his lower back. He initially had severe pain with radiation down both legs. He was taken to the ER and was prescribed Toradol 60 mg and Decadron w/ Depomedrol 10mg/80mg and released to follow up. The claimant returned to the ER several days later for continued pain and a CT scan was ordered. Past surgical history is positive for low back injury in 1994 which was treated with an IDET. He gradually improved from that injury and had no real problems with his low back at the time of his injury.

September 11, 2012, CT Lumbar Spine, Impression: Mild disk bulge with mild facet arthropathy at L4-5, and mild disk bulges but no acquired stenotic disease in the remainder of the lumbar levels.

October 9, 2012, evaluated the claimant who reported previous treatment include pain medications, antiinflammatories, and steroid shots and Toradol shots. He presented with significant low back pain with radiation down the left leg to his foot. On physical examination he had decreased flexion secondary to pain, straight leg raise was negative bilaterally, and DTRs were 2+ on lower extremities. Impression: Low back pain with radiculopathy down left leg. Plan: Continue medications, refilled Norco #30 and MRI.

October 29, 2012, MRI Lumbar Spine, Impression: 1. Narrowed L3-4 disk space with posterolateral bulging, left greater than right. Slight impingement on the exiting left nerve root suspected. 2. Small focal central protrusion, L4-5. Mild posterolateral bulging as well, right greater than left. 3. Mild bulging disk with posterolateral extension, left greater than right at L5-S1.

November 7, 2012, PA-C re-evaluated the claimant and referred to orthopedic for consultation.

December 17, 2012, evaluated the claimant for lumbar pain with radicular pain down both hips and legs, primarily on the left. Past treatment included Hydrocodone, Xanax, and Mobic and limitation of activities. On exam there was tenderness over both sciatic outlets, mainly on the left. He had a slight left antalgic gait. Straight leg raising was positive on the left at between 30 and 45 degrees and on the right at between 45 and 60 degrees. Deep tendon reflexes were 2+ in the knees, trace in the right ankle and absent in the left ankle. There was a little weakness of bilateral foot and great toe dorsiflexion and plantar flexion, mainly on the left, with scattered hypalgesia in both L5 and S1 dermatomes, again mainly on the left side. He had no lower extremity pathologic reflexes. Diagnosis: Post-traumatic multilevel lumbar disk disease with a chronic mechanical low back disorder and lumbar radiculopathies with neurologic defect. Plan: Prescribed Hydrocodone 10 mg to take for severe pain. Left L5-S1 epidural Depo-Medrol injection was recommended.

January 9, 2013, Operative Report, Procedure: Left L5-S1 epidural injection.

May 9, 2013, evaluated the claimant and reported that the claimant had received some benefit from the ESI and was able to return to work, however, he was having a quite bit more pain with severe lumbosacral pain and bilateral radiating hip and leg pain, worse on the left. On exam he walked with a flexed posture to the low back. Straight leg raising was positive bilaterally. He had some neurologic deficit, with numbness, dysesthesias, and weakness, particularly in the left leg. Plan: He was given some Hydrocodone 7.5 mg and a lumbar myelogram was requested for further investigation.

May 17, 2013, performed a UR. Rationale for Denial: A lumbar CT scan on 9/11/12 showed mild multilevel disc bulges. A lumbar MRI on 10/29/12 showed disc bulging at L3-4, L4-5, and L5-S1. He has received a left L5-S1 ESI on 01/19/13 that gave some benefit and was able to return to work. On 5/9/13, he presented for a follow-up evaluation with complaints of low back pain. The physical examination showed a positive bilateral straight leg raise test, "some" neurologic deficit with numbness, dysesthesias, and weakness particularly in the left leg. However, an objectively measured MMT, dermatomal sensory examination, deep tendon reflexes and straight leg raise test were not documented to suggest presence of a significant neurological pathology to the lumbar spine. Also, a discussion regarding the additional benefits of this study for this patient was not provided considering that his previous MRI that was not deemed inadequate or of poor quality. There was also no contemplated surgical intervention for this patient.

June 6, 2013, performed a UR. Rationale for Denial: Official Disability Guidelines, in reference to authorization of myelography, indicate this diagnostic testing is not recommended except for selected indications including when magnetic resonance imaging cannot be performed or in addition to magnetic resonance imaging such as if imaging is unavailable, contraindicated, or inconclusive. Guidelines further indicate the use of myelography is recommended for demonstration of the site of the cerebral spinal fluid leak, surgical planning, radiation therapy planning, diagnostic evaluation of spinal or basal cisternal disease, poor correlation of physical findings with magnetic resonance imaging, or if the use of magnetic resonance imaging has been precluded due to claustrophobia, technical issues, safety reasons, or surgical hardware. Based on the documentation provided, the patient presents with continued complaints of severe lumbosacral and bilateral radiating hip and leg pain despite previous epidural steroid injection with previous magnetic resonance imaging indicating multilevel disc pathology and protrusions that was not deemed inadequate or of poor quality to warrant the use of myelography at this time. Furthermore, the patient does not present with any other indications including the precluded use of magnetic resonance imaging that would warrant the use of myelography at this time.

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

The previous adverse determinations are upheld. The claimant underwent a lumbar MRI in October 2012 which showed disc bulging at L3-4, L4-5, and L5-S1.

The claimant presented on May 9, 2013 with continued lumbosacral pain following an ESI. noted some neurologic deficit, with numbness, dysesthesias, and weakness, particularly in the left leg on physical examination. requested a lumbar myelogram for further investigation. According to the Official Disability Guideline, myelography is not recommended except for selected indications including demonstration of the site of a cerebrospinal fluid leak, surgical planning especially in regards to the nerve roots, radiation therapy planning, diagnostic evaluation of spinal or basal cisternal disease, poor correlation of physical findings with MRI studies, and use of MRI precluded because of claustrophobia, technical reasons, safety reasons or surgical hardware. The provided documentation contained no indication that the MRI was of poor quality, nor any surgical discussion. There was also no indication that the use of a MRI would be precluded due to the listed reasons. Therefore, the request for Outpatient Lumbar Myelogram 62284 does not meet ODG criteria and is non-certified.

PER ODG:

Myelography	<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)**