



Notice of Independent Review Decision - WC

DATE OF REVIEW:

07/18/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

CT Myelogram Lumbar and Thoracic Spine

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

Board Certified in Orthopedic Surgery

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 or not medical necessity exists for each of the health care services in dispute.

CT Myelogram Lumbar and Thoracic Spine – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- SOAP Note, 10/11/10, 11/22/10, 01/24/11, 03/12/13
- Lumbar Myelogram and CT, 10/22/10
- Operative Report, 12/23/10, 01/13/11
- Electrodiagnostic Testing, 01/07/11
- Prescription, 03/12/13
- Work Comp Pre-Auth Request Form, 04/26/13
- Denial Letters, 05/01/13, 06/17/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient had back and leg pain. She had undergone a three level anterior and posterior fusion in 1999, but had not improved after the surgery. In August 2009, she had a pain pump implanted that was not as effective as it had been when it was first implanted. She had no relief of her right sided leg cramping and low back pain. A lumbar myelogram and CT performed on 10/25/10 showed at L3-L4-L5 interbody and posterolateral fusions present, solidly confluent at L3-L4 and L4-L5 and at L5-S1. There were shallow ventral defects present at T11-T12 and L1-L2, levels of disc degeneration and annular bulging, but no stenosis. There was minimal retrolisthesis in lumbar extension above the fusion at L2-L3, which no disc protrusion, ventral defect, significant facet joint arthrosis, or stenosis. In December 2010, a right and left T12-L1/L2 paralumbar posterior medial branch block was performed. Electrodiagnostic studies were performed in January 2011, which were mildly abnormal of the bilateral lower extremities, showing positive electrodiagnostic evidence of a bilateral upper lumbar radiculopathy which appeared to be primarily in the upper lumbar levels, L1 through L3. A second medical branch block was performed in January 2011. The patient's symptoms were worse and she could not have injections due to having the pain pump. The provider requested a CT myelogram of the lumbar spine to consider surgical options based on the findings.

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

The Peer Review of 05/01/13 noted that there was absence of clear evidence of new or progressive neurological deficits and/or the failure of a reasonable course of conservative treatment and, therefore, the repeat study was not recommended. After a review of the records, the current report did not document information that would support the need for a repeat CT myelogram within the Official Disability Guidelines (ODG) recommendations as first there is supposed to be an inconclusive x-ray noted, which was not documented, and there should be a trial of conservative treatment prior to considering imaging studies. Again, that was not documented as noted in the 03/12/13 report. Therefore, the request for the CT myelogram of the thoracolumbar spine does not meet ODG recommendations.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- DWC - DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**