

# US Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/07/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: CT Myelogram lumbar

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O. Board Certified Neurological 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 medical necessity exists for each health care service in dispute.** It is the opinion of this reviewer that medical necessity is not established for CT myelogram lumbar

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

**PATIENT CLINICAL HISTORY [SUMMARY]:** The claimant is a xx year old female whose date of injury was xxxx. Records indicated that the claimant was involved in a motor vehicle accident on that date with injuries to the cervical spine and lumbar spine. She had a history of previous cervical spine surgeries and surgery to the lumbar spine. Per cervical consultation with Dr. dated 10/16/12, she continued to complain of neck stiffness with low back pain, bilateral leg pain with numbness and tingling, and failure of conservative, with failure of conservative treatment. Conservative treatment included physical therapy, chiropractic and lumbar epidural steroid injections. X-rays of the lumbar spine including flexion extension views revealed L4-5 and L5-S1, laminotomy at L4-5 and laminectomy at L5-S1 with pedicle

screws bilaterally at L4, L5, and S1 with plating. There appeared to be no posterior bone formation. There was no screw fracture. Significant adjacent segment disease was noted at the L3-4 level. Physical examination of the neck and upper extremities revealed well healed anterior incision, equal and symmetrical biceps, brachioradialis, and triceps showed no gross motor deficits or paresthesias. Tinel, Phalen, and Hoffman were negative. There were positive compression test and negative shoulder abduction tests bilaterally. Cervical spine range of motion was limited and worse in forward flexion than extension.

Examination of the back lower extremities revealed well healed midline incision, mild paravertebral muscle spasm, positive sciatic notch tenderness bilaterally, negative foot and finger test, positive extensor lag, positive flip test bilaterally, positive Lasegue on the left at 45 degrees, positive Braggard, and hypoactive knee jerk bilaterally. There were paresthesias in the S1 nerve root distribution bilaterally, and L3 and L4 nerve root distribution on the left and the right with anterior thigh and weakness of quadriceps on the left.

A request for CT myelogram lumbar was reviewed on 01/07/13 and non-certified. It was noted that the treating physician requested a gadolinium enhanced MRI scan of the lumbar spine stating that the claimant was a surgical candidate. Conservative treatment included epidural steroid injections, chiropractic care, and physical therapy. There was documentation of a 12/21/12 utilization review determination where the request for lumbar spine was non-certified and where the reviewing physician stated that significant artifact would result with the use of MRI and these studies would be essentially non-diagnostic. The reviewer continued to state that there was reference to possible pseudoarthrosis at the prior surgical level, and CT would be indicated to evaluate the residual bone stock; however, there was no clinical documentation from the treating physician of a request for lumbar spine CT myelogram. Therefore, medical necessity of the request was not substantiated.

A reconsideration request for CT myelogram lumbar was reviewed on 01/18/13 and the request was non-certified and it was noted that the request was previously denied due to no clinical documentation from the treating physician for request for lumbar spine CT myelogram. There was still no clinical documentation from the treating physician to support the CT myelogram or provide rationale. Official Disability Guidelines recommend CT myelogram to evaluate residual bone stock due to possible pseudoarthrosis at the prior surgical levels; however, given the lack of clinical documentation provided, the request for appeal request for CT myelogram was non-certified.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The claimant is noted to have sustained injuries secondary to motor vehicle accident. She has a history of previous surgery to the cervical spine and lumbar spine. She is status post L4-S1 fusion. Per surgical consultation dated 10/16/12, the claimant continued to complain of neck pain and back pain and bilateral leg pain. X-rays of the lumbar spine were performed on this date, but no radiology report was submitted for review. According to the note, the plan was to continue the work up with a gadolinium enhanced MRI scan of the lumbar spine. A utilization review determination dated 12/21/12 non-certified the request for lumbar spine MRI. There is no subsequent progress note or other clinical documentation from the requesting provider documenting a request for CT myelogram of the lumbar spine including the rationale for such imaging study. Based on the clinical data provided, it is the opinion of this reviewer that medical necessity is not established for CT myelogram lumbar in accordance with Official Disability Guidelines criteria.

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

ACOEM-AMERICA 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)