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## Notice of Independent Review Decision

**DATE OF REVIEW:** 11/3/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The item in dispute is the prospective medical necessity of CT Lumbar Myelogram.

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

The reviewer is a Medical Doctor who is 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)

The reviewer agrees with the previous adverse determination regarding the medical necessity of CT Lumbar Myelogram.

A copy of the ODG was provided by the Carrier/URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The female reportedly fell and was injured on xx/xx/xx. Diagnoses include thoracic or lumbosacral neuritis or radiculitis. The patient underwent a L4-5 laminectomy with fusion on 06/17/2014. On 09/20/2014, there was ongoing/exacerbated low back pain that radiated into the right hip. Exam revealed heel and toe walk were non-problematic Lumbosacral

paraspinal muscle spasms were noted. The neuro. exam was noted to be intact except 4/5 right quadriceps and diminished right patella reflex.

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

The patient did not have significant objectively severe or progressive neurological dysfunction. There were no weeks/months of conservative treatment trial and failures documented. Therefore, applicable ODG criteria have not been met and the request is not medically necessary.

**Reference:** ODG Low Back Chapter

**ODG Criteria for Myelography and CT Myelography:**

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:
    - a. Claustrophobia
    - b. Technical issues, e.g., patient size
    - c. Safety reasons, e.g., pacemaker
    - d. Surgical hardware

**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)