

# Icon Medical Solutions, Inc.

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## Notice of Independent Review Decision

**DATE:** August 15, 2014

**IRO CASE #:**

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

CT Myelogram of the Lumbar Spine

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

The reviewer is certified by the American Board of Orthopaedic Surgery with over 42 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.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who injured her back while working on xx/xx/xx.

08/14/13: Electromyography report. IMPRESSION: Normal EMG findings in the right lower extremity, L2-S1 nerve root distribution. EMG findings of large amplitude motor unit action potentials in the left peroneus longus muscle are consistent with a diagnosis of old injury to the muscle. Muscle relaxation was not obtainable for EMG examination of the lumbar paraspinal muscles. Normal nerve conduction studies of the right and left peroneal and sural nerves.

09/30/13: MRI of the right hip report. IMPRESSION: Normal MRI examination of the right hip.

10/16/13: MRI of the lumbar spine report. IMPRESSION: 4 mm left paracentral disc protrusion at L5-S1, which mildly impinges upon the thecal sac and the left S1 nerve root. The disc protrusion also severely narrows the left lateral recess. Mild disc desiccation at L5-S1 with an acute full thickness radial tear in the posterior fibers of the annulus fibrosis.

02/13/14: The claimant was evaluated for pain in her right thigh. On exam, her gait was normal. DTRs were 1+. Sensation was intact. SI provocative testing/prone lumbar instability was positive. The impression was lumbosacral pain and dysfunction. Therapy was recommended.

03/17/14: Procedure note. POSTOPERATIVE DIAGNOSIS: Chronic low back pain. Sacroiliac joint dysfunction. Lumbar facet syndrome. PROCEDURE PERFORMED: Right sacroiliac joint injection.

03/19/14: The claimant was evaluated. ROM was intact. Reflexes were 2+. Kemps was negative. SLR was negative. Motor strength was 4/5 bilateral inversion L4.

03/25/14: The claimant was evaluated. She complained of continued pain in her back and legs. She reported radiating pain from the lumbar region into the right lower extremity. The symptoms were worsened with standing, walking, lifting, and carrying. She reported 80% relief when taking Tramadol, etodolac, and OTC medication. She denied bowel or bladder incontinence. On exam, she was able to heel and toe walk and perform a full squat without motor weakness related deviation. Her gait was normal. ROM 50 lumbar flexion, 20 lumbar extension, 50 right hip flexion, 45 right hip abduction, 35 right hip extension. It was recommended that she participate in a trial of active rehab program due to her work capacity being at medium but her job requiring heavy.

04/10/14: A letter was submitted. "Ms. injured her lumbar spine on the job on xx/xx/xx. She has undergone conservative therapy that includes physical therapy and injections; all of which have failed to abate her symptoms. Ms. lumbar spine symptoms have worsened over the last few months. She complains of a sharp stabbing pain in her right buttocks, as well as numbness/tingling in the 4<sup>th</sup> and 5<sup>th</sup> digits of her right foot. She also displays weakness in her lower extremities. was referred for an orthopedic consult. Based on his examination of her, correlated with her MRI films, and the fact that she has failed all forms of conservative therapy, is recommending that she have a CT myelogram. This imaging is medically necessary so that the full extent of her injury can be understood."

04/23/14: Physical therapy note (provider name illegible, no facility name listed) indicates that the claimant had worse objective findings with lumbar spasm, tenderness, and reduced motion. She had numbness/paresthesias in the right lower extremity. She reported an increase in lower back pain. She was advised to go the ER if her pain increased anymore. It was recommended to hold off on therapy until her symptoms decreased.

06/18/14: Physical therapy notes remained unchanged from 04/23/14 with the exception of the claimant noting that she had feelings of depression. She was to follow up in two weeks.

06/24/14: UR. RATIONALE: I have not been able to determine the medical necessity of this request. At this point, as stated, there is no documentation of any physical exam findings or claimant complaints. Therefore, the request is recommended for noncertification.

07/03/14: UR. RATIONALE: Additional records included a letter of medical necessity. The guidelines indicate CT myelograms are supported for demonstration of a site of a cerebral spinal fluid leak, surgical planning, radiation therapy planning, poor correlation of physical findings with an MRI, or an MRI being precluded. No recent clinical note was provided with a complete physical examination demonstrating worsening of symptoms as stated in the letter of medical necessity. The electrodiagnostic studies were negative for radiculopathy in the lower extremities. There is no indication there is a consideration of surgical intervention and no indications the claimant cannot undergo an MRI because of claustrophobia, technical issues, safety reasons, or surgical hardware. The request for reconsideration of a CT myelogram of the lumbar spine is not certified.

07/07/14: Physical therapy note indicates that the claimant presented with high levels of low back pain. She stated that Tramadol was not helping at all. She was frustrated because she had not shown any improvement in a few months. Objective findings were of lumbar spasm, tenderness, and reduced motion. She stated that driving had become difficult because it hurt her leg to press the accelerator. She also complained of pain in her right groin area. CT myelogram was recommended. It was noted that "CT myelo was denied by ins carrier. Denial states that peer doctor called me Friday afternoon and we discussed the case. This is not true, as I never received a peer call and we are not even open on Fri afternoons." The plan was to resubmit for authorization for CT scan and myelogram. She was to follow up in two weeks.

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

The previous adverse decisions are upheld. The most recent physical exam submitted for review failed to demonstrate any neurological signs. While CT/myelography may be helpful in surgical planning, there is no indication that a surgical recommendation has been made. Additionally, there have been no contraindications to MRI. As the claimant does not meet ODG criteria, the request for CT Myelogram of the Lumbar Spine is not medically necessary.

**ODG:**

Myelography	<b>ODG Criteria for Myelography and CT Myelography:</b> <ol style="list-style-type: none"><li>1. Demonstration of the site of a cerebrospinal fluid leak (postlumbar puncture headache, postspinal surgery headache, rhinorrhea, or otorrhea).</li><li>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.</li><li>3. Radiation therapy planning, for tumors involving the bony spine, meninges, nerve roots or spinal cord.</li><li>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.</li></ol>
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	<p>5. Poor correlation of physical findings with MRI studies.</p> <p>6. Use of MRI precluded because of:</p> <ul style="list-style-type: none"> <li>a. Claustrophobia</li> <li>b. Technical issues, e.g., patient size</li> <li>c. Safety reasons, e.g., pacemaker</li> <li>d. Surgical hardware</li> </ul>
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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)**