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Notice of Independent Review Decision

August 11, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CT myelogram lumbar spine

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

Physical Medicine and Rehabilitation Physician

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Overturned (Disagree)

Medical documentation supports the medical necessity of the health care services in dispute.

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 patient is male who was injured on xx/xx/xx. The exact mechanism of injury is not available.

2008 – 2010: On September 22, 2008, performed catheter-guided lumbar lysis of adhesions at left L5 and S1. The postoperative diagnosis was lumbar radiculopathy, postlaminectomy syndrome and lumbar postoperative epidural scarring.

On October 13, 2008, evaluated the patient for low back pain and failed back surgery syndrome. The lysis of adhesions provided excellent pain relief, almost 90%, which lasted for only two weeks. The patient was utilizing hydrocodone, Naprosyn, Ambien CR and Neurontin. diagnosed lumbar radiculopathy, postlaminectomy syndrome, lumbar spondylosis, chronic pain syndrome and

chronic opioid usage in a controlled fashion. He recommended continuing present treatment and discussed the possibility of a spinal cord stimulator (SCS).

On December 5, 2008, performed percutaneous placement of SCS lead left OCTAD electrode, percutaneous placement of left peripheral nerve stimulator QUAD lead and complex intraoperative programming.

On December 11, 2008, the patient reported his quality of life and pain control had improved significantly with the SCS. The pain had reduced to 75%; he had decreased his opioid intake by 50% and his function had improved by 50%. continued the present treatment and scheduled the patient for a permanent SCS placement.

On February 20, 2009, performed percutaneous placement of SCS lead right and left OCTAD electrode, implantation of internal pulse generator and complex intraoperative programming.

On March 2, 2009, noted significantly improved pain control with the SCS. The patient was able to perform a lot of activities of daily living (ADL). The pain was reduced by 80%. The diagnoses were lumbar radiculopathy, lumbar herniated disc and chronic pain syndrome.

On March 23, 2009, noted the SCS was controlling pain significantly and the patient's sleep had improved. The patient reported that his quality of life and pain control had improved significantly.

On July 2, 2009, noted pain was well controlled on the current regimen and the patient's activities had improved. continued the treatment.

On October 1, 2009, the patient complained of insomnia that was not controlled by Ambien. He reported the quality of life and pain control had improved significantly. continued the treatment.

On March 4, 2010, noted the patient was due to undergo a functional capacity evaluation (FCE). He had limitation to his activities following surgery. Medications seemed to be helping with his pain. continued the treatment.

On June 30, 2010, the patient reported he had undergone designated doctor evaluation, the results were not available. Medications were helping to function. continued present treatment.

On October 8, 2010, noted the medications of Ambien CR, Mobic, Neurontin and Norco were controlling the pain. continued present treatment.

2011 – 2013: On February 8, 2011, noted that the current medications were controlling pain. He recommended continuing ongoing treatment.

On June 8, 2011, noted the medications were no longer controlling his pain. The patient was working as a veterinary technician and this had increased his pain. stopped tramadol and Norco and started Butrans patch.

On July 14, 2011, the patient reported that the Butrans helped during the early part of the day but was not strong enough at the end of the day. increased Butrans to 10 mcg.

On October 19, 2011, the patient reported that medications were controlling his pain very well. ordered urine spot screen.

On November 21, 2011, noted that medications were controlling his pain very well. The last urine drug test was negative. ordered urine spot screen and continued the present treatment.

On December 19, 2011, noted the medications were controlling pain very well. The patient's last urine drug test was negative. The patient reported some issues with getting the patch to stick. ordered a urine spot screen and continued the present treatment.

On February 16, 2012, noted the patient had undergone a colectomy for perforated diverticulosis. His last urine drug test was negative for Butrans. The patient reported that he was using his medications as prescribed. stopped Butrans and started hydrocodone. He ordered a urine drug test to see if there was an issue with absorption of Butrans transdermal patch as opposed to an oral medication. referred the patient to a multidisciplinary chronic pain program.

On March 19, 2012, the patient reported that his current medications were not controlling his pain very well. He wanted to be on something other than the Norco and was also concerned about his liver function secondary to his acetaminophen intake. ordered urine spot screen and continued present treatment. He started Nucynta.

On May 16, 2012, noted improved functioning and decreased pain with medications. The patient rated his pain at 3/10. He requested for an extended release version of the Nucynta as he was working full time and sometimes was unable to get to take medications regularly leading to an increase in pain. started Nucynta ER.

On August 28, 2012, the patient reported improved functioning and decreased pain with the current medication regimen. The medications were controlling pain for the most part and his quality of life and his pain control was improving such that he was able to perform a lot of ADLs. Examination revealed increased range of motion (ROM) since May 16, 2012, with decreased muscle spasms in the lumbar spine. prescribed Nucynta ER and continued present treatment.

On November 27, 2012, noted improved functioning and decreased pain with medications. The patient rated his pain at 2/10. There was increased ROM and

decreased muscle spasm. prescribed Motrin and Nucynta and continued present treatment.

On February 26, 2013, noted worsening low back pain radiating down the left lower extremity. The patient reported that the quality of pain had changed and he had noticed increasing weakness in the left leg. The pain was rated as 4/10. The patient reported that his physical functioning along with family and social relationships had improved. He was able to walk for longer distances and do more with the medications. His mood and sleep had improved. Examination revealed flattening of the normal lumbar curvature, mild facet tenderness at L4-L5 and L5-S1 on the left with mild paraspinous tenderness on both sides, positive nerve root stretch signs in the sitting position with concordant pain to the back and leg at 45 degrees on the left side and positive Kemp's maneuver on the left side. The last urine drug test was consistent with the prescribed medications. prescribed ibuprofen and ordered computerized tomography (CT) scan of the lumbar spine.

On March 11, 2013, a computerized tomography (CT) scan of the lumbar spine revealed: (1) Anterior bulging of the disc at T12-L1 with mild anterior degenerative spondylosis, minimal posterior annular bulging and evidence of a pain management stimulator lead extending into the spinal canal and extending superiorly into the lower thoracic spine. (2) There was mild anterior degenerative spondylosis at L1-L2 and mild posterior bulging of the disc producing a mild impression on the anterior thecal sac without moderate or severe spinal stenosis. (3) There was mild posterior bulging of the annulus at L2-L3 producing a mild impression on the anterior thecal sac and mildly accentuating a developmentally small central spinal canal. The inferior aspect of the neural foramen was mildly narrowed on both sides related to bulging of the disc but no compression of the exiting root sleeve. (4) There was disc space narrowing related to degenerative disc disease (DDD) at L3-L4 with mild retrolisthesis of L3 on L4. Anterior bulging of the disc with anterior degenerative spondylosis was present. There was posterior bulging of the disc. This bulging disc in association with ligamentum flavum hypertrophy narrowed the central spinal canal. There was acquired central spinal canal stenosis of a moderate-to-severe degree at this level. The inferior aspect of the neural foramen was mildly narrowed on both sides related to bulging of the disc but no compression of the exiting root sleeve. (5) At L4-L5, there was evidence of prior bilateral laminectomy and interbody fusion. There was disc prosthesis within the disc space with incorporation of the disc prosthesis into the adjacent endplates of L4 on L5. Old pedicle screw tracks were present bilaterally at L4 and L5. There appeared to be some partial fusion of the posterolateral bony mass on both sides. (6) At L5-S1, there was evidence of prior laminectomy. There was disc prosthesis within the disc space and there was incorporation of the prosthesis into the adjacent endplates of L5 and S1 with some fusion across the disc space. Old pedicle screw tracks were present. There was no bony central spinal canal stenosis or bony foraminal stenosis. A posterolateral bony fusion had been performed. The right neural foramen was mildly narrowed related to mild bony hypertrophy but no compression of the exiting root sleeve was seen.

In April and May 2013, the patient underwent physical therapy (PT) evaluation and was recommended therapy.

On May 28, 2013, reviewed CT of the lumbar spine. prescribed ibuprofen and referred the patient to a spine surgeon as the patient had adjacent spinal disease.

On August 13, 2013, noted worsening of pain over the last few months. The patient was unable to stand for any length of time without being in pain. Examination revealed a positive straight leg raising (SLR) test bilaterally. prescribed Nucynta ER, scheduled the patient for SCS reprogramming and referred him to a spine surgeon.

On December 3, 2013, the patient reported worsening pain in the left lower extremity and L4-L5 dermatomal distribution. The patient reported that at his work he was unable to lift anything heavy or bend without being in significant pain. The pain level was 6/10. He was unable to walk for longer distances and was unable to do ADLs with the medications. prescribed Nucynta ER and Medrol Dosepak while awaiting imaging studies.

2014: On March 25, 2014, the patient reported his pain had worsened over the last few months. Medrol Dosepak helped for a short time. The patient was unable to stand for any period of time or do any activity without being in significant pain. There was worsening of pain in the left lower extremity and L4-L5 dermatomal distribution. The patient was unable to lift anything heavy or bend without being in significant pain. The CT myelogram had been denied. The current pain score was 5/10. The patient was unable to walk long distances and was unable to do ADLs without the medications. His last urine drug testing (UDT) from September 19, 2013, was consistent with the prescribed medications. The current medication regimen was not controlling the pain. The patient was utilizing gabapentin, lisinopril and hydrochlorothiazide, Nucynta ER and Zoloft. The patient was 5'6" and weighed 240 pounds with a BMI of 39. SLR test was positive on both sides and sensation in the left L4 dermatomal distribution was decreased. The left ankle reflex was decreased. prescribed Nucynta ER and ordered a CT myelogram of the lumbar spine due to worsening neurological symptoms.

Per a utilization review dated June 9, 2014, the request for CT myelogram of the lumbar spine was denied with the following rationale: *"The patient is male with a date of injury of xx/xx/xx. The compensable body part is the low back. The request is for CT myelogram of the lumbar spina as an outpatient. I attempted to reach the requesting physician, I left a voice message but did not receive a callback, is a pain management physician. He saw the claimant on March 25, 2014. There does not appear to be any follow up evaluation since that time. indicated that the claimant's pain has worsened over the last few months. He had given him a Medrol Dosepak, which helped for a short period of time. He is having difficulty standing for any long period of time and he has noted some worsening pain in the left lower extremity in the L4-L5 dermatomal distribution and he is having difficulty at work with lifting and bending and he is working full time. It*

is not clear whether these findings are any different than what has been going on for several years other than increase in his pain. He has not been seen since March 25, 2014, over two and a half months. There is no indication that the claimant has been seen by any spinal surgeon. There is no indication that the claimant is a candidate for any type of surgical intervention. At this time: the request for CT myelogram is recommended for non-certification as being not medically reasonable or necessary. There is no updated clinical examination to justify the request.”

Per a reconsideration review dated June 12, 2014, the appeal for CT myelogram lumbar spine was denied with the following rationale: *“This is an appeal of a previously noncertified request for CT myelogram of the lumbar spine, as an outpatient. The claimant is a male who was injured on xx/xx/xx, in a mechanism that was not described in the provided records. The claimant was diagnosed with thoracic or lumbosacral neuritis/radiculitis. Current medications included gabapentin, lisinopril hydrochlorothiazide, Zoloft and Nucynta ER. The evaluation on March 25, 2014, noted history of lumbar radiculopathy and postlaminectomy syndrome. There were subjective complaints of pain that has worsened over the last few months. The claimant reported that Medrol Dosepak had helped. The claimant reported being unable to stand for any activity without being in significant pain. The physical examination noted cranial nerves were intact. There was no significant change since the previous evaluation on December 3, 2013. SLR testing was positive on both sides. Extensor hallucis longus tendons were 5/5. There was decreased left dermatomal distribution and decreased left ankle reflex. I discussed this case who reports the claimant is now having new neurologic deficits. He reports no recent physical therapy or lower levels of care have been instituted. The claimant has a spinal cord stimulator and therefore cannot get an MRI. The request was previously non-certified on June 9, 2014, due to lack of recent clinician information to justify the request and lack of indication the claimant was a candidate for cervical intervention. No additional medical records were submitted for review. The previous non-certification is supported. There is no documentation of any surgical planning. Based on the medical documentation provided for review and the peer-reviewed, evidence-based guidelines, the request is not medically supported. The appeal request for CT myelogram of the lumbar spine, as an outpatient is not certified.”*

On June 17, 2014, noted worsening of pain. The patient was unable to stand for any time or doing any activity without being in significant pain. The patient reported worsening pain in the left lower extremity and L4-L5 dermatomal distribution. He also reported that at work he was unable to lift anything heavy or bend without being in significant pain. The carrier had denied PT and CT myelogram. The pain was rated at 5/10. Examination revealed a positive SLR test bilaterally, decreased sensation in the left L4 dermatomal distribution and decreased left ankle reflex. ordered CT myelogram of the lumbar spine due to worsening neurological deficits. Gabapentin was increased to 600 mg twice a day along with ibuprofen 800 mg t.i.d.

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

Based on the medical records there is documented neurologic decline with decreased L4 sensory and left ankle reflex. Given the individual cannot have an MRI due to a spinal cord stimulator the CT would be second choice. Although there is no mention of surgical planning with neurologic deterioration it would be a consideration. Therefore, the decision should be overturned.

ODG reports: Not recommended except for selected indications below, when MR imaging cannot be performed, or in addition to MRI. Myelography or CT-myelography may be useful for preoperative planning. ([Bigos, 1999](#)) ([Colorado, 2001](#)) Myelography and CT Myelography has largely been superseded by the development of high resolution CT and magnetic resonance imaging (MRI), but there remain the selected indications for these procedures, when MR imaging cannot be performed, or in addition to MRI. ([Mukherji, 2009](#))

ODG Criteria for Myelography and CT Myelography:

1. Demonstration of the site of a cerebrospinal fluid leak (post lumbar puncture headache, post spinal 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:

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES