

AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

[Date notice sent to all parties]: January 5, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar CT Myelogram

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

This physician is Board Certified in Orthopaedic Surgery with over 14 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured on xx/xx/xx and has underwent multiple back surgeries since. It is not clear what the initial injuries were or mechanism of injury.

08-05-09: Operative Report. Preoperative Diagnoses: 1. Failed back syndrome; 2. Lower extremity radiculopathy; 3. Lumbago; 4. Chronic pain syndrome. Postoperative Diagnoses: 1. Failed back syndrome; 2. Lower extremity radiculopathy; 3. Lumbago; 4. Chronic pain syndrome.

11-11-10: CT L-Spine Post Myelogram. Impression: 1. Posterior decompression and fusion in the lumbar spine as discussed above. Moderate narrowing of the

central canal at L2-3 primarily due to facet overgrowth and endplate spondylosis.
2. Degenerative neural foraminal narrowing at L1-2, L2-3.

01-03-12: Lumbar Spine 2 or 3 VW. Impression: Previous fusion, no acute disease.

09-26-13: XR Lumbar Spine AP Lateral Obliques Flexion and Extension.
Impression: 1. Previous lumbar decompression and fusion, without apparent complication. 2. Chronic L2 spondylosis, with no spondylolisthesis. 3. Spinal cord stimulator.

10-29-13: Thoracic Spine Two Views, Lumbar Spine Minimum 4 Views.
Impression: Thoracic spine: 1. Spinal stimulator electrodes overlying dorsal canal at T8-T10. Wires exiting canal dorsally at T10-11, passing to a generator in the left flank. 2. Slight right convex scoliosis (Cobb angle less than 10 degrees). 3. Normal vertebral body heights. Multilevel endplate osteophytes consistent with degenerative disease, with anterior fusion of T7-8. Impression: Lumbar Spine: 1. Shallow scoliosis convex left at L1-2, exaggerated changes in L1-2 disc height between flexion and extension views, suggesting ligamentous laxity and degenerative disc disease. Bulky endplate osteophytes. 2. L2-3 fusion construct in anatomic alignment. Bilateral pedicle screws (grossly well-positioned and well seated) connected to posterior rods. Probable posterior element fusion with bone graft. Bulky endplate osteophytes. 3. Solid L3-S1 fusion with bulky interbody and posterior element bone graft. 4. Bilateral sacroiliac joint degeneration.

10-29-13: Lumbar Spine Two or Three Views. Impression: 1. L2-3 fusion construct in anatomic alignment. Bilateral pedicle screws (grossly well-positioned and well seated) connected to posterior rods. Posterior bone graft, with some evidence of fusion. Bulky endplate osteophytes. Probably laminotomy. 2. Solid L3-S1 fusion with bulky interbody and posterior element bone graft laminectomies. 3. Bulky endplate osteophytes at the remaining levels. No evidence of a pars defect. 4. Osteopenia. 5. Spinal stimulator. Electrodes overlying canal at T8-T10. Wires exiting canal dorsally at T11-12 and passing to a generator in the left flank.

10-29-13: Office Note. Subjective: The claimant was last seen 11/10/09 and returns today for follow up regards to her lumbar spine stating that she has been having some low back pain and also complaining of having bilateral lower extremity radiculopathy and decreased sensation. She also complaining of having pain with change of positions that this causes more significant problems. Current pain level is 10/10. Current Medications: hydrocodone 10/325, methocarbamol 500mg, Lisinopril 10mg, Metformin 1000mg, Lantus 24 units, Novolog 10units, Vitamin E 800 units, ?B-12 500mg. PE: Sensation decreased on the L3-4 and L4-5 dermatomes bilaterally. She has a positive SLR on the left, positive trochanteric pain bilaterally, positive FABER signs on the left, positive SI pain bilaterally. Imaging: Lumbar spine x-rays show the claimant does have interbody posterior fusion L3-S1 with instrumentation and dynamic stabilization at L2-3. It appears to be in good position and she has a dorsal column stimulator as

well. Assessment: 1. Status post fusion lumbar spine; 2. Status post dorsal column stimulator implant; 3. Low back pain 724.2; radiculopathy 722.4; possible disc herniation 722.10; facet arthropathy 721.73, degenerative changes lumbar spine 722.52. Plan: The recommendation will be to obtain a CT/myelogram of the lumbar spine. We will see her back after this is done. We will see her back sooner should any problems develop. Claimant was given ER warnings for increasing pain, weakness, bowel or bladder incontinence.

11-12-13: UR performed. Reason for denial: Recommend adverse determination. This request is not supported since only one office note with a date of service of 10/29/13 was submitted for review. Thus there is no documentation of a progression of a neurological deficit. There is also no documentation what specific lumbar pathology is meant to be ruled out by this requesting imaging.

11-19-13: UR performed. Reason for denial: Based upon the medical documentation presently available for review, the above noted reference would not support this specific request to be one of medical necessity. The above noted reference would not support this specific request to be one of medical necessity, as there is no documentation to indicate the presence of any new changes on neurological examination compared to previous. As a result, presently, medical necessity for this request is not established per criteria set forth by ODG Low Back Chapter.

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

The previous adverse determinations are upheld and agreed upon. The CT myelogram is not indicated at the present time for this claimant. A CT myelogram is used to determine the degree of neural compression as well as the condition of the hardware and bony fusion following spine surgery. did not specifically state why he requested a CT myelogram for this patient. Based on one office note, it is unclear whether there has been any recent change in the patient’s neurologic status that could be associated with potential worsening neural compression. Additional documentation is required to show changes in the patient’s neurologic status. The patient has documented neuroforaminal narrowing at L1-2 and L2-3, according to the 2010 CT myelogram. As long as there are no changes in the neurologic status of the patient, a new study would not show any additional pathology. Furthermore, there are no issues with the hardware or bony fusion, according to the records reviewed. The 2010 CT myelogram did not document any issues with hardware or fusion. The radiographs from October 29, 2013 also did not point toward any hardware or fusion problems. Therefore, after review of the medical records and documentation provided, the request for Lumbar CT Myelogram is not medically necessary and denied.

Per ODG:

Myelography	<p>ODG Criteria for Myelography and CT Myelography:</p> <ol style="list-style-type: none"> 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
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	<p>whether surgical treatment is promising in a given case and, if it is, can help in planning surgery.</p> <p>3. Radiation therapy planning, for tumors involving the bony spine, meninges, nerve roots or spinal cord.</p> <p>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.</p> <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"> a. Claustrophobia b. Technical issues, e.g., patient size c. Safety reasons, e.g., pacemaker d. Surgical hardware
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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)