



**MEDICAL EVALUATORS
OF T E X A S** ASO, L.L.C.

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Notice of Independent Review Decision

DATE OF REVIEW: July 8, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

1 Computed Tomography Myelogram for the Lumbar Spine with Standing Flexion/Extension

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

This case was reviewed by a physician who holds a board certification in Orthopedic Surgery and is currently licensed and practicing in the state of Texas.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Type of Document Received	Date(s) of Record
MRI Lumbar Spine	07/08/2013
X-rays Lumbar spine, 7 views	08/19/2013
Progress Note	07/19/2013
Progress Note	08/17/2013, 10/08/2013, 10/18/2013, 02/06/2014, 04/22/2014, 05/03/2014
Physical Therapy Outpatient Evaluation	08/28/2013
Physical Therapy Progress Report	09/25/2013

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This is a male who on xx/xx/xx was injured lower back. He fell backwards and struck and struck his left buttock into a corner of a metal table. He began having a pulling sensation across his low back which worsened with pain into the left posterior leg. The treatment



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history includes medications, physical therapy and ESIs with no significant pain relief. He had MRI of the lumbar spine dated 07/09/2013 that showed multiple degenerative disk and facet changes with bilateral L5 pars defects and grade 1 anterolisthesis of L5 on S1. He had x-rays of the lumbar spine dated 08/19/2013 that showed diffuse degenerative disc disease, worsening anterior spondylolisthesis at L5-S1, and pars defect on the right at L5. Two views of the entire spine on 06/06/2014 showed S-shaped scoliosis of the thoracolumbar spine with approximately 9 degree dextroscoliosis of the mid thoracic spine and 10 degrees of levoscoliosis of the lumbar spine. A progress report dated 06/06/2014 indicates patient presented with complaints of low back pain radiating to bilateral lower extremities. On physical exam, the sensation to the lower extremities to light touch was symmetric. Negative Hoffman. The reflexes were 2+ C5, C6, C7, L4, and S1. recommended myelogram and CAT scan of the lumbar spine with flexion-extension views as well as 360° lumbar fusion at the L5-S1 level of the lateral L5-S1 followed by posterior millimeters pedicle screw fixation. The coverage for CT myelogram of the lumbar spine is denied due to lack of evidence to support its use.

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

The surgeon has requested CT myelogram in addition to preoperative MRI as an adjunct for preoperative surgical planning, as stated in his notes. This modality allows precision planning for screw placement to avoid neural structures and prevent intraoperative complications. CT myelogram is supported by the ODG for this purpose. Therefore, I disagree with the previous adverse determination.

ODG Chapter – Low Back – Lumbar & Thoracic (acute and chronic) Myelography

Not recommended except for selected indications below, when MR imaging cannot be performed, or in addition to MRI. Myelography and CT Myelography OK if MRI unavailable, contraindicated (e.g. metallic foreign body), or inconclusive. (Slebus, 1988) (Bigos, 1999) (ACR, 2000) (Airaksinen, 2006) (Chou, 2007) Invasive evaluation by means of myelography and computed tomography myelography may be supplemental when visualization of neural structures is required for surgical planning or other specific problem solving. (Seidenwurm, 2000) Myelography and CT Myelography have largely been superseded by the development of high resolution CT and magnetic resonance imaging (MRI), but there remain the selected indications below 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 (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.



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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)