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Notice of Independent Review Decision

September 2, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CT myelogram lumbar spine with contrast

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

Orthopedic Physician

REVIEW OUTCOME:

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

Upheld (Agree)

Medical documentation **does not support** 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 a female who was injured on xx/xx/xx. The exact mechanism of injury is not available.

Pre-Injury Records

On September 19, 2007, performed percutaneous placement of Medtronic E contact lead 45 cm in length introduced first at L1-L2 with inability to steer to the right and then at L2-L3, internalization of lead with placement of an anchor and 21 cm extension wire, implantation of restorer IPG battery, rechargeable in the right buttock and complex programming.

On July 18, 2011, computerized tomography (CT) of the lumbar spine revealed a dorsal stimulator wire, significant broad-based posterior disc protrusion at L4-L5,

asymmetric to the left with marked left and moderate right foraminal narrowing, severe degenerative disc disease (DDD) at L5-S1 with severe right bony foraminal narrowing and mild left foraminal narrowing and some spinal stenosis at L3-L4 and L4-L5.

On July 18, 2011, reviewed the CT scan and assessed Modic changes at L5-S1 with Knutson phenomenon, total collapse of the disc space, anterior osteophytes, normal lordosis, and a very spacious canal with calcifications of the posterior annulus particularly on the left side. The patient complained of back pain as an 8 and leg pain as a 9. recommended a transforaminal epidural steroid injection (ESI).

On December 21, 2011, performed bilateral transforaminal epidurography with fluoroscopic interpretation, transforaminal exiting L5 neurography with fluoroscopic interpretation and transforaminal ESI at L5-S1.

On January 17, 2012, noted the ESIs were not helpful and in fact they made her worse. The patient had stents placed in both legs in January 2012. She had some thrombosis in the legs. Examination revealed tenderness over the sacroiliac (SI) joints, limited and painful flexion and extension, 3+ pitting edema, decreased sensation involving the right posterior leg, difficulty performing manual motor testing because of swelling and the leg pain, pain in same area of the lower back on straight leg raising (SLR) but not down the legs, back pain with hip motion and Patrick maneuver bilaterally, difficulty performing Gaenslen's maneuver which apparently was positive and inability to turn over prone on the table to do Yeoman maneuver. requested an SI joint injection. He was concerned that the patient might have recurrent thrombophlebitis. Medications were refilled (Flexeril, Norco, Klonopin and Ambien).

On May 22, 2012, noted the SI joint injection was denied. Examination revealed a positive Fortin test, pain with flexion and extension. The patient stood with a little asymmetry. Sitting root test was positive mostly for knee pain but not for back pain on the right than the left, supine SLR was positive, reflexes were absent. She had low back pain with hip motion on the left. Patrick maneuver on the right caused left SI area pain and Gaenslen and Yeoman maneuver were markedly positive. refilled medications and resubmitted a request for SI injection.

On August 9, 2012, evaluated the patient for back pain and leg pain and numbness on the side of her foot. Magnetic resonance imaging (MRI) had shown a large herniation at L4-L5 on the left. There was a dominant left low back pain into the left leg. History was positive for disc removal in 1994, tissue removal in 2006-2008 and spinal cord stimulator (SCS) placement in 2012. Medical history was positive for high blood pressure, stomach ulcer, degenerative arthritis, anxiety and depression. Examination revealed paravertebral muscle tenderness bilaterally, positive SLR on the left at 75 degrees, pain with seated SLR that was located at back, buttocks, thigh and lower leg. diagnosed lumbar V syndrome with herniated nucleus pulposus (HNP) at L4-L5. Norco, Ambien, Flexeril and Cymbalta were refilled.

On January 16, 2013, noted the patient was unable to get her medications. The patient complained of difficulty regulating her diabetes. She reported neuropathy-type symptoms in her feet. The patient was also getting overstimulation from her SCS. diagnosed lumbar radicular syndrome and refilled Norco, clonazepam and Flexeril.

On July 15, 2013, noted the patient had a lot of back pain despite her stimulator. She had more left leg pain, previously it was predominantly right. The pain medicine was not covering very well. Examination revealed right light touch abnormal at the L5 and S1 dermatomes. X-rays showed SCS lead still behind the body of T10 and T11, the same place where it was on x-rays two years ago. refilled Norco, tramadol and Ambien.

Post-Injury Records

On January 7, 2014, noted the patient was getting overstimulation from her stimulator. She was taking too many of her Norco. Her podiatrist had started her on gabapentin which was somewhat helpful. She was getting allodynia involving the right foot. diagnosed lumbar radicular syndrome with SCS, diabetic neuropathy and peripheral vascular disease (PVD). He refilled Norco, Ambien, Ultram and clonazepam.

On July 7, 2014, noted that Worker's Compensation would not give Flexeril. Examination findings were unchanged. increased clonazepam, prescribed Flexeril and refilled Norco and Ambien.

Per a utilization review dated July 11, 2014, the request for CT myelogram of the lumbar spine was denied with the following rationale: *"The patient is a female who reported an injury on xx/xx/xx, the mechanism of which was not provided in the records submitted for review. The patient is currently diagnosed with lumbar intervertebral disc without myelopathy; lumbar radicular syndrome; diabetic neuropathy; peripheral vascular disease and anxiety disorder. A request was made for CT/myelogram of the lumbar spine. Subsequent to the injury, the patient had undergone conservative treatment in the form of medication management, epidural steroid injection which weren't helpful, chiropractic care (worsened symptoms), physical therapy (with improvement), and psychological consultations ("no change*"). The CT of the lumbar spine on July 18, 2011, showed a dorsal stimulator wire, disc protrusion at L4-L5, severe degenerative disc disease at L5-S1 with severe right bony foraminal narrowing, and spinal stenosis at L3-L4 and L4-L5. The patient underwent a disc removal in 1994, stents were placed in both legs in January 2012, and SCS was implanted in 2012. There was note of two undated laminectomies. A prior MRI showed a large herniation at L4-L5 on the left. In the report dated July 15, 2013, it was stated the patient is having a lot of back pain despite the stimulator. It was noted the patient thought her leads have moved. The patient reported that she was having more leg pain. The patient did have stents placed in both legs and circulation was better. X-rays showed her SCS lead is still behind the body of T10 and T11, the*

same place where it was on x-rays two years prior. The patient was seen on January 7, 2014, and she stated that she was getting overstimulation from her stimulator. The patient stated she tried reprogramming it unsuccessfully. It was mentioned in this report that they may need to remove the stimulator. The patient had radiculopathy, neuropathy, and circulatory issues. The patient was on Norco and Ultram. It was noted the patient was getting allodynia involving the right foot. Upon examination the paravertebral muscles were tender bilaterally. The straight leg raise test was positive on the right side at 90 degrees. Light touch was abnormal at the right S1 dermatome. Lower extremity strength was present and asymmetrical. According to the office visit report dated July 7, 2014, the patient was seen for her six-month follow-up. The patient continued on Norco; she had other medical problems and she had to limit it to six a day. The patient was very anxious and she was asking if she can increase her clonazepam. Objective findings noted she was sitting comfortably and did not have any difficulty acquiring a full, upright position when getting out of the chair. It was noted the patient's gait was balanced. Her lower extremity strength was symmetric and light touch was abnormal at the S1 dermatome. The patient's clonazepam was increased to 2 mg t.i.d. p.r.n. The Norco and Ambien were refilled. New medications were Klonopin and cyclobenzaprine. There was no noted progression of neurologic symptoms in the recent medical report to warrant investigation with an imaging study. Moreover, guidelines recommend use of myelogram for surgical planning. However, there was no mention of any contemplated operative procedure for this patient in the report dated July 7, 2014, to warrant the requested study. In consideration of the foregoing issues and the referenced evidence-based practice guidelines, the medical necessity of the request has not been established. Given the above, the request for CT/Myelogram lumbar spine with contrast 72132, 62284 and 72265 is not certified."

Per a reconsideration review dated July 30, 2014, the appeal for CT/myelogram lumbar spine was denied with the following rationale: "The patient is a female who reported an injury on xx/xx/xx, the mechanism of which was not provided in the records submitted for review. The patient is currently diagnosed with lumbar intervertebral disc without myelopathy; lumbar radicular syndrome; diabetic neuropathy; peripheral vascular disease; and anxiety disorder. A request was made for CT/Myelogram of the lumbar spine. According to the office visit report dated July 7, 2014, the patient was seen for her six-month follow-up. The patient continued on Norco; she had other medical problems and she has to limit it to six a day. The patient was very anxious and she was asking if she can increase her clonazepam. Objective findings noted she was sitting comfortably and did not have any difficulty acquiring a full, upright position when getting out of the chair. It was noted the patient's gait was balanced. Her lower extremity strength is symmetric and light touch is abnormal at S1 dermatome. The patient's clonazepam was increased to 2 mg t.i.d. p.r.n. The Norco and Ambien were refilled. New medications were Klonopin and cyclobenzaprine. The initial request for CT/myelogram was denied on the basis that there was no noted progression of neurologic symptoms or deficits in the recent medical report to warrant investigation with an imaging study and the guidelines recommend use of myelogram for surgical planning. There was no mention of any contemplated

operative procedure for this patient in the report dated July 7, 2014, to warrant the requested study. No additional information has been received. Given the above information, the previous decision of non-certification is upheld.”

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

The CT/Myelogram as requested would not be considered as medically necessary. This individual is with a chronic condition with an injury dating to xx/xxxx. The records reflect a history of back surgery predating the injury date as well as placement of a spinal cord stimulator in 2012. Treatment has consisted of epidural steroid injections, medications, and office visits. There is no evidence within the record of a progressive neurologic deficit, acute injury or exacerbation of her condition, and there is no evidence of a change in her clinical condition. The record is also not reflective of any plans for surgical intervention and the provider did not clearly outline in what way the requested CT/Myelogram would impact the treatment plan. On the basis of the available information, the determination that medical necessity for the CT/Myelogram is not met, would be upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Low back chapter - 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.

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