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Notice of Independent Review Decision

Case Number:

Date of Notice: 06/11/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

CT myelogram lumbar spine

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:

Patient Clinical History (Summary)

is an individual. On 07/10/02, she was taken to surgery for a complete anterior discectomy at L4-5 with decompression, and an anterior interbody device was also placed. On 04/15/15, the patient was seen in clinic with complaints of low back pain and right lower extremity pain. It was noted she had undergone a placement of an artificial disc at the L4-5 level in 2002. She had been seeing a pain management physician and had been taking Ibuprofen as well as Amitriptyline and noted the medication was not providing her much relief. She denied bowel or bladder issues at that time. She reported having chiropractic care, physical therapy, and injections as well as a psychological consultation with no change in her symptoms. On exam straight leg raise was positive on the left at 60 degrees, and pain with seated straight leg raise was located to the back. Right anterior tib strength was 5- and left anterior tib strength was 5. Right EHL strength was 5- and left EHL strength was 5. Quadriceps strength was normal. X-rays showed good placement of the artificial disc at the L4-5 level, with mild scoliotic curve. There was good placement of the disc on the lateral view with no evidence of subsidence or lucency with loss of disc height at the L5-S1 level. Flexion and extension x-rays showed no evidence of instability. A CT myelogram was recommended secondary to the fact that an MRI would produce too much scatter from the artificial disc to evaluate properly either the level above where the disc was or at the L5-S1 level below.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On 04/21/15, a utilization review report for the submitted CT myelogram of the lumbar spine reviewed the request as if it was for an injection rather than a CT myelogram. It was also noted there were no clear objective changes or evidence of progressive neurological deficits to warrant a repeat imaging study, and there were no prior diagnostic imaging studies found in the records despite a surgery with new complaints of right pain since 2002 and multiple steroid injections. Therefore the request for a CT myelogram was not supported and the recommendation was for non-certification. On 05/14/15, a utilization review appeal for the CT myelogram of the lumbar spine noted that there was no substantial documentation of changes in the physical examination findings suggestive of progressive or objective evidence of neurological deficits, and

repeat imaging is not recommended without objective documentation of substantial changes in the physical examination findings suggestive of progressive neurological deficits. Therefore the request was non-certified.

Guideline criteria for a CT myelogram would be for surgical planning especially in regards to the nerve roots, radiation therapy planning for tumors, diagnostic evaluation or spinal or basal cisternal disease and/or infection, or for poor correlation of physical findings with MRI studies or if MRI is precluded due to surgical hardware. The provider stated that due to the presence of hardware, the CT myelogram would be preferable than the MRI. However, guidelines indicate that repeat MRIs should not be performed unless there is documentation of a significant change in symptoms and/or findings suggestive of significant pathology such as tumor, infection, fracture, and/or recurrent disc herniation. For this patient, plain x-rays failed to demonstrate instability and/or hardware failure. There is no indication that the patient is considered a tumor patient or that there is significant progressive neurological deficits. Therefore it is the opinion of this reviewer that the request for a CT myelogram of the lumbar spine is not medically necessary and the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and Guidelines
- ☐ European Guidelines for Management of Chronic Low Back Pain
- ☐ Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)