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May 4, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar CT myelogram and x-rays with flexion/extension, AP and lateral views

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:

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 a male (5 foot, 4 inches tall and weighing 135 pounds) who was injured on xx/xx/xx, when pulling a bag of cement. The patient had acute onset of severe low back and right lower extremity pain.

On May 5, 2003, the patient was admitted to the hospital with severe and intractable low back pain with right lower extremity pain. It was noted the patient had been treated with multiple conservative measures in the past, which failed.

On May 5, 2003, performed anterior lumbar interbody fusion (ALIF) with femoral rings and anterior instrumentation from L3-L4 through L5-S1, redo right L3-L4 laminectomy, and redo right trans-facet decompression at L3-L4 and L4-L5, right-sided facet fusion from L3 through S1 and percutaneous pedicle screw fixation.

The patient was discharged home on May 9, 2003, after an uneventful hospital stay.

On October 2, 2003, for noted the patient had ongoing discomfort with pain primarily into the left leg, but overall doing much better than previous to the surgery. A computerized tomography (CT) scan of the lumbar spine of September 25, 2003, was reviewed showing postoperative changes at L4 through S1 levels, mild-to-moderate chronic degenerative changes throughout the lumbar spine and no definitive evidence of neural compromise.

A magnetic resonance imaging (MRI) of the lumbar spine on June 22, 2004, showed severe changes of degenerative disc disease (DDD) seen throughout the lumbar spine with multilevel fusion extending from L3 through S1, persistent multilevel foraminal stenosis most severe at L4-L5 and L5-S1, diffuse spinal stenosis most pronounced at L2-L3 and L4-L5 and clumping of distal nerve roots within the thecal sac suggesting possible arachnoiditis.

The patient underwent lumbar epidural steroid injections (ESIs) on January 21, 2006, June 23, 2006, August 29, 2006, November 10, 2006, March 13, 2007, April 20, 2007 and May 18, 2007.

An MRI of the lumbar spine without contrast dated April 3, 2007, revealed overall there had not been a significant interval change in appearance. Extensive postoperative changes were seen extending from L3 to S1 with neuroforaminal narrowing present at most of the operative levels. There also appeared to be a large osteophyte on the left at L3-L4, which severely narrowed the left lateral recess, protruding into and narrowing the spinal canal diameter. There was also DDD at L1-L2 and L2-L3, and narrowing of the spinal canal diameter at those levels. There was evidence of arachnoiditis at L5-S1.

On July 10, 2007, noted the patient had a history of lumbar disc injury and cervical disc injury. The patient reported ongoing left leg weakness and spasms in the legs, more at night, more headaches resulting from muscle tension in the neck area. The patient was utilizing Norco, Duragesic patch, Zanaflex, Zonegran, Zantac, Norvasc, ASA, Prozac and MiraLax. recommended increasing the dose of Zanaflex and repeating the lumbar ESIs.

On August 24, 2007, the patient stated he still had some leg pain, joint pain and morning stiffness. The last injection was still helping. There was hyporeflexia and distal weakness.

evaluated the patient on October 1, 2007, for increased weakness of the left arm and increased tremors affecting both arms that had gotten worse over the last couple of weeks. The claimant still had neck pain, numbness and weakness of the right leg. It was noted the claimant had a previous cervical surgery and several low back surgeries. A repeat cervical CT scan was recommended to evaluate for the integrity of the hardware.

An evaluation on January 12, 2015, noted the patient was status post lumbar interbody fusion in 1994 and two more lumbar revisions in 1999 and 2000. The procedure in 2000 provided significant relief until approximately two to three years

prior. The patient stated he was on a gradual decline with severe low back pain with right lower extremity pain along the anterolateral thigh and calf and constantly into the toes of the right foot with numbness, tingling and weakness in a similar distribution. The right leg would also give way from time to time. The patient reported a previous work-related injury in xxxx which included low back pain with subsequent surgical decompression procedure in xxxx. The patient described 100% resolution of the pain. The patient had a history of hypertension, myocardial infarction, skin cancer and coronary artery disease. Lumbar range of motion was significantly restricted in forward flexion secondary to pain. Motor exam revealed 4/5 strength of the iliopsoas on the right, otherwise 5/5 throughout. Deep tendon reflexes were +2 throughout and symmetrical. Plantar responses were flexor bilaterally. The patient ambulated with an anthropoid posture with the aid of a four tip cane. He was unable to effectively perform heel walk, toe walk and tandem walk secondary to balance and pain. Straight leg raise was positive at 30 degree on the right and 60 degree on the left. Sensory exam revealed a hypoesthetic region over the L5 and S1 distributions on the right to pinprick and light touch, otherwise intact. Coordination was intact in finger to nose exam and rapid alternating movements. There was a 7-inch surgical scar in the midline of the lumbar region. There were six one-inch surgical scars adjacent to the midline scar, three on the right and three on the left. reviewed the lumbar MRI of April 3, 2007, and recommended obtaining a computerized tomography (CT) myelogram of the lumbar spine to better evaluate the central canal and the neural foramina, and obtaining lumbar spine series in the standing position to include flexion and extension views.

A utilization review on March 16, 2015, denied the request for outpatient CT myelogram of the lumbar spine with the following rationale: *“The guidelines only support CT myelogram when MRI cannot be performed or is contraindicated. The claimant has had previous MRIs of the lumbar spine on June 22, 2004, and April 3, 2007. There is no documentation supporting an MRI is unable to be performed because of claustrophobia, technical issues or safety reasons. There is no physical examination by the treating physician documenting any radiculopathy. Based on the medical documentation provided for review and the peer-reviewed, evidence-based guidelines, the request is not medically supported. The request for outpatient lumbar CT myelogram is not certified.”*

Per reconsideration review dated April 1, 2015, the request for outpatient CT myelogram of the lumbar spine was denied with the following rationale: *“The request was previously noncertified on March 13, 2015, due to the lack of documentation supporting an MRI unable to be performed due to claustrophobia, technical issues, or safety reasons, as the claimant had two previous MRIs in June 2004 and April 2007 and the lack of radiculopathy on examination. No additional documentation was provided for review. The previous non-certification is supported. The most recent evaluation documented positive straight leg raise testing, but there was no documentation of radiation or if this was only low back pain. Previous hyporeflexia, distal weakness, and positive straight leg raise testing was noted in the evaluations from 2007; however, no dramatic changes were noted in the subjective and objective findings. The guidelines state that CT*

myelography is indicated for demonstration of cerebrospinal fluid leak, surgical planning, radiation therapy planning, poor correlation of physical examination findings with MRI studies, or when MRI is precluded because of technical reasons, safety reasons, surgical hardware or claustrophobia. There was no indication the claimant could not undergo a current MRI. There is no documentation that the claimant is under consideration for surgical planning. The appeal request for lumbar CT myelogram is not certified.”

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

The request is for a lumbar CT myelogram as well as flexion/extension and AP/lateral views. This individual underwent previous lumbar surgery including a fusion. The records reflect that he has not had any imaging since 2007 but is having progressive back and leg pain. In light of the recurrent symptoms, certainly further imaging would be indicated. A lumbar CT myelogram would be appropriate in light of the prior surgery as well as plain films including flexion/extension views. The claimant has been imaged in the past, but there has not been an MRI since 2007. Lumbar CT myelogram would be appropriate to determine if there is evidence of residual neural impingement. Flexion/extension views would be indicated to determine if there is any evidence of instability. Plain films would also be appropriate as part of the workup.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES