

Clear Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 31, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical CT scan with myelogram thin section

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

M.D., Board Certified Orthopedic Surgeon

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

Adverse Determination Letters, 9/5/07, 8/8/07
ODG Guidelines and Treatment Guidelines
Office notes, Works, 05/11/07, 05/18/07, 05/24/07, 06/07/07, 06/13/07, 06/20/07,
06/27/07, 07/13/07, 07/20/07, 10/08/07, 10/17/07
Physician Physical Capabilities Assessment Form, 05/11/07
MRI Cervical Spine, 06/11/07
MRI Lumbar Spine, 06/11/07
Office notes, 07/25/07, 08/08/07, 08/29/07
Office note, 08/08/07

Peer review, 09/05/07
Office notes, 09/21/07, 09/25/07
Quantitative Functional Evaluation, 09/24/07
Authorization for facet injection, 10/17/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year old who was at a stop sign and was rear ended by a van on xx/xx/xx. The claimant began treating at for both neck and back pain. Diagnosis was cervical and lumbar sprain/strain. The lumbar complaints resolved. The 06/11/07 cervical MRI report revealed thickening of the posterior longitudinal ligament and focal prominence of the posterocentral annuli at the C2-3 through C5-6 level and central canal stenosis to borderline stenotic at the C2-3 and C5-6 levels. The spinal cord was normal in size, position, configuration and signal intensity from the cervicomedullary junction through T4-5. Further evaluation of the posterior annular anatomy at the C2-3 thru C6-7 levels would be best afforded by thin section CT cervical myelography, if clinically indicated. The lumbar MRI report revealed early nuclear dehydration and/or degeneration involving L1-2 through L5-S1 discs, no herniated nucleus pulposus, spinal stenosis or facet joint arthropathy. The claimant continued to treat with with physical therapy, off work, antiinflammatory medications and restricted duty. Exam findings on multiple serial office visits were restricted neck range of motion, spasm and tenderness. The claimant denied weakness, numbness or tingling. Dr. saw the claimant on 07/25/07 for persistent complaints of neck pain. The claimant noted no improvement since his injury. Examination revealed intact sensory, limited cervical range of motion and intact motor. Dr. noted that the radiologist had recommended Cervical CT myelogram to help define the anatomy. Diagnosis was possible cervical radicular syndrome. Dr. recommenced a CT myelogram. The claimant saw Dr. on 09/21/07 who recommended cervical facet injections and physical therapy for the lumbar spine. Dr. noted severe strength deficits in both neck and back on 09/25/07. The claimant returned to on 10/17/07. Examination revealed no weakness, no abnormal reflexes and a negative cervical compression test. No further treatment recommendations were made.

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

I do not see the medical indication for the cervical CT scan with myelogram thin cut section based on the medical records I have for review. While I understand that this person was involved in a motor vehicle accident and has ongoing neck complaints, there is no documentation of neurologic deficit, protective muscle spasm, or other objective abnormality. Plus he has undergone a cervical MRI documenting no evidence of a disc herniation or bone fracture. While the radiologist described the need for a thin cut CT myelogram to evaluate the annular appearance at multiple levels, I don't understand what that test is going to reveal that the MRI test already did not reveal. There is no discussion in the record that this claimant has an undiagnosed disc herniation or undiagnosed structural instability and there is no documentation in the record of any type of spinal cord injury or ligamentous abnormality of the cervical spine.

Therefore it is not clear to me as to what information would be gained by this requested test and therefore, I do not see the medical indication for this test.

Official Disability Guidelines Treatment in Workers' Comp 2007 Updates, Cervical

Not recommended except for indications below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging. Patients who do not fall into this category should have a three-view cervical radiographic series followed by computed tomography (CT). In determining whether or not the patient has ligamentous instability, magnetic resonance imaging (MRI) is the procedure of choice, but MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. (Anderson, 2000) (ACR, 2002) See also ACR Appropriateness Criteria™. MRI or CT imaging studies are valuable when potentially serious conditions are suspected like tumor, infection, and fracture, or for clarification of anatomy prior to surgery. MRI is the test of choice for patients who have had prior back surgery. (Bigos, 1999) (Colorado, 2001) For the evaluation of the patient with chronic neck pain, plain radiographs (3-view: anteroposterior, lateral, open mouth) should be the initial study performed. Patients with normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging. If there is a contraindication to the magnetic resonance examination such as a cardiac pacemaker or severe claustrophobia, computed tomography myelography, preferably using spiral technology and multiplanar reconstruction is recommended. (Daffner, 2000) (Bono, 2007)

Indications for imaging -- CT (computed tomography):

- Suspected cervical spine trauma, alert, cervical tenderness, paresthesias in hands or feet
- Suspected cervical spine trauma, unconscious
- Suspected cervical spine trauma, impaired sensorium (including alcohol and/or drugs)
- Known cervical spine trauma: severe pain, normal plain films, no neurological deficit
- Known cervical spine trauma: equivocal or positive plain films, no neurological deficit
- Known cervical spine trauma: equivocal or positive plain films with neurological deficit

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)