



Notice of Independent Review Decision

DATE OF REVIEW: 10/9/08

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for a myelogram of the cervical spine with post CT scan.

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

Texas licensed 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The previously denied request for a myelogram of the cervical spine with post CT scan.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Fax Cover Sheet/Comments dated 9/26/08, 9/25/08.
- Notice to . of Case Assignment dated 9/26/08.

- Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 9/26/08.
- Note dated 9/25/08.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 9/25/08.
- Notice of Assignment of Independent Review Organization dated
- Request Form Request for a Review by an Independent Review Organization dated 9/24/08.
- Determination Notification Letter dated 9/11/08, 9/5/08.
- Follow-Up Visit Note/Report dated 8/28/08, 7/31/08, 6/26/08, 6/3/08, 4/24/08, 3/26/08, 2/12/08, 1/24/08, 12/5/07, 11/9/07, 10/10/07, 9/12/07, 8/28/07, 8/15/07, 7/11/07, 6+/20/7, 6/6/07, 5/9/07, 4/11/07, 3/14/07, 2/9/07, 1/18/07, 1/12/07, 12/15/06, 11/27/06, 1/17/06, 11/7/06, 10/20/06, 9/29/06, 9/5/06, 9/1/06, 8/4/06, 7/7/06, 6/12/06, 5/22/06, 5/15/06, 4/17/06, 3/20/06, 2/17/06, 2/13/06, 1/20/06, 12/21/05, 11/23/05, 10/24/05, 9/26/05, 9/21/05.
- Radiology Report/Review dated 4/24/08, 7/13/04.
- Cervical Spine CT Scan dated 11/27/06, 7/15/04.
- Operative/Procedure Report dated 8/23/06, 8/9/06, 1/11/06, 1/4/06, 5/19/04, 8/26/03, 5/5/03.
- Follow-Up SOAP Note dated 8/16/06.
- Patient Information/Paramedic Assessment/Treatment Form dated 9/16/05.
- Patient Care Record dated 9/16/05.
- Psychological Evaluation Report dated 9/7/05.
- Pre-Surgical Note and Discussion dated 9/7/05.
- Follow-Up Progress Note dated 8/22/05, 8/2/05, 6/6/05, 5/18/05, 4/6/05, 3/11/05, 1/31/05, 1/5/05, 11/17/04, 10/18/04, 9/13/04, 8/11/04, 6/7/04, 12/12/03, 11/3/03, 9/5/03, 8/27/03, 7/9/03, 5/9/03, 4/11/03, 4/3/03, 3/26/03, 3/13/03, 3/5/03, 1/22/03, 12/11/02, 10/28/02, 8/28/02, 7/26/02, 6/14/02, 4/17/02, 3/8/02, 2/4/02, 1/9/02, 11/21/01, 10/26/01, 8/10/01, 7/23/01, 6/15/01, 3/15/01, 12/22/00, 10/4/00.
- Limited Spine CT Scan Report dated 1/13/05.
- History and Physical Examination Report dated 11/19/04, 4/19/04, 12/19/02, 2/4/02.
- Follow-Up Progress Note dated 11/17/04, 11/1/04, 10/13/04, 10/8/04, 10/4/04, 9/22/04, 9/15/04, 9/13/04, 9/9/04, 9/7/04, 9/1/04, 8/30/04, 8/27/04, 8/23/04.
- Referral for Impairment Rating of the Right Shoulder dated 11/8/04.
- Re-Evaluation Report/Letter dated 8/16/04.
- Cervical Spine dated 7/15/04.
- Evaluation Report/Letter dated 7/13/04.
- Letter of Medical Necessity dated 6/11/04.
- Texas Workers' Compensation Commission Hearings Division Decision and Order/Statement of the Case dated 9/11/02, 4/3/02.
- Benefit Review Conference Report dated 9/11/02.
- Texas Workers' Compensation Work Status Report dated 8/28/02.

- Daily Summary dated 6/16/02, 6/15/02, 6/14/02, 6/13/02, 6/12/02, 2/4/02.
- Progress Report #3 dated 6/7/02.
- Second Opinion Consultation Report/Letter dated 5/21/02.
- Initial Examination Report dated 4/30/02.
- Cover Page/ Supplemental Information/Cervical/Lumbar Spine Range of Motion/ARCON EG – Extremity Range of Motion Goniometer/Functional Capacity Evaluation Report/Testing Results/Review of Medical History and Physical Exam/Report of Medical Examination dated 2/15/02, 2/4/02, 1/26/01.
- Functional Capacity Evaluation Report dated 2/4/02.
- Report of Medical Evaluation dated 8/9/00.
- Right Shoulder/Left Elbow/Cervical Spine CT Scan/X-Ray Report dated 8/16/99.
- Medical Necessity Letter (unspecified date).

No guidelines were provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx years
Gender: Female
Date of Injury: xx/xx/xx
Mechanism of Injury: Lifting tires and batteries.

Diagnosis: C6 radiculopathy and degenerative disk disease of the lumbar spine, status post epidural steroid injections of the cervical, lumbar spine, status post facet injections of the lumbar spine, status post spinal cord stimulator injection and lumbar facet syndrome, S1 joint dysfunction and lumbar stenosis.

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

The claimant is a xx-year-old female with the date of injury of xx/xx/xx. The mechanism of the injury was lifting tires and batteries. The diagnosis was C6 radiculopathy and degenerative disk disease of the lumbar spine status post epidural steroid injections of the cervical lumbar spine, status post facet injections of the lumbar spine, status post spinal cord stimulator placement, and diagnoses of lumbar facet syndrome, sacroiliac (SI) joint dysfunction, and lumbar stenosis. Dr. has noted that both, the back and neck were problems from the day of the injury. The claimant had complaints of right upper extremity pain associated with the neck pain. The claimant has prior radiographic evidence of multiple levels spondylosis, loss of disk height at C5-6 and C6-7. An electromyogram (EMG) previously revealed C6 radiculopathy on the right. The claimant has had a prior CT scan of the cervical spine that was performed on November 27, 2006 noting left unciniate hypertrophy with no stenosis, and at C4-5 1 to 2 mm posterior central disk bulge. The claimant has had ongoing neck pain. Most recently, Dr. noted the neck pain became more significant after the spinal cord stimulator in the lumbar spine had been implanted. When seen by

Dr. in consultation, the claimant noted a CT myelogram was ordered to assess for cervical spinal cord compression. A CT scan without the myelogram was looking for bony details but unable to judge the neural elements for spinal cord compression adequately. He did not discuss the claimant's prior MRI having been without significant signs of spinal cord impingement or problems with the neural elements. The claimant does continue to have Lhermitte sign noted along with a Spurling's maneuver on the right greater than the left in multiple records by Dr. . The rationale for non-certification for the requested CT myelogram is in line with prior recommendations for an adverse determination. ODG states "*Not recommended except for surgical planning. Myelography or CT-myelography may be useful for preoperative planning. (Bigos, 1999) (Colorado, 2001).*" The ODG also states, "Emergence of a red flag. Physiologic evidence of tissue insult or neurologic dysfunction. Failure to Progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure." *ACOEM also would not support this procedure under these conditions.* This claimant does not fulfill these criteria and therefore, the denial is upheld.

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

ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE.

American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Second Edition. Chapter 8, pages 177-178.

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.

Official Disability Guidelines, Treatment Index, 6th Edition (web), 2008, Cervical-Myelography.

- 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 MEDICAL LITERATURE (PROVIDE A DESCRIPTION).
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION).