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Notice of Independent Review Decision

DATE OF REVIEW: January 29, 2009

IRO CASE #:

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

This case was reviewed by an Orthopaedic Surgeon, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Contrast x-ray of neck; injection for myelogram; CT with dye; fluoroguide for spine

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o January 14, 2008 through December 3, 2008 utilization review reports
- o September 24, 2008 through November 21, 2008 records from M.D.
- o August 20, 2008 emergency department and CT cervical spine report from Health System and Hospitals
- o October 10, 2008 cervical spine MRI report by M.D.
- o November 6, 2008 EMG/NCV report by M.D.
- o October 19, 2000 cervical spine MRI report by M.D.
- o November 4, 2004 cervical myelogram and post-myelogram computed tomography report by M.D.
- o January 23, 2002 operative report regarding a 2 level complete corpectomy at C4-5 vertebral bodies
- o August 29, 2002 report by M.D.
- o August 26, 2008 emergency department discharge instructions from Health System
- o September 3, 2008 emergency department discharge instructions from Health System

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records submitted for review, the patient is a male who sustained an industrial injury on XX/XX/XX. On January 23, 2002, the patient underwent surgery on his neck consisting of a two level complete corpectomy at C4-5 vertebral bodies with donor fibular strut graft from C3 to C6. Stabilization was performed of the anterior cervical spine with a soft anterior cervical plate and screws from C3 to C6.

The records include a November 4, 2004 cervical myelogram and post-myelogram CT of the cervical spine report. The impression was as follows: "Postoperative changes at C4 and C5 corpectomy with strut graft extending from C3 to C6 as well as instrumentation. There is solid fusion. There is a congenitally narrow canal. There is some ossification of the posterior

longitudinal ligament at C6 and to a lesser extent at C3 but this does not appear to result in significant stenosis of the spinal canal. C6-7 spondylosis and midline disc bulging. Decreased filling of the C7-T1 nerve root sheaths, right greater than left, with bilateral foraminal disc protrusions and some uncinete hypertrophy and ligamentous hypertrophy at C7-T1. Marked anterior spondylotic bony ridging and ossification of the anterior longitudinal ligament at C2-3."

On August 20, 2008, the patient underwent a CT of the cervical spine with evidence for postsurgical change with anterior fusion from the C3 to C6 levels with associated fusion of the disc spaces and placement of a long bony strut with associated partial corpectomy of C4 and C5. The appearance of the hardware is otherwise unremarkable. There is evidence for degenerative disease at the C2-3 and C6-7 levels. Bony productive change involves the posterior vertebral bodies extending into the spinal canal approximately 3 mm. Neural foraminal narrowing is also identified.

An MRI was performed on the October 10, 2008 with an impression as follows: "Prior fusion anteriorly with probably multifocal partial corpectomy and tubular bone grafting. The anterior plate appears to extend from C3 through C6 or C5-6. Mild cord atrophy from approximately C4 through C5. Small cystic focus in the right side of the cord at the C5 level likely representing a tiny focus of myelomalacia. Mild asymmetric left foraminal narrowing at C4-5, C5-6 and C6-7 on the basis of asymmetric uncinete arthropathy and hypertrophy. Asymmetric left foraminal stenosis on the left at C6-7 due to asymmetric uncinete osteophytosis and probably some associated protrusion of disc material.

An October 29, 2008 utilization review report rendered a non-certification for a repeat cervical myelogram and another post-myelogram CT. The report states that the patient has undergone multilevel cervical fusion and had recently begun to experience a steady increase in neck symptoms and the expansion of paresthesias of the hand. A CT scan of the neck obtained earlier in the year documented the instrumentation and fusion were intact without evidence of a clinically significant identifiable neural compressive lesion. Given the progression of predominantly distal sensory changes, a repeat electrodiagnostic study was certified. However, the determination of the necessity of the cervical myelogram should await the outcome of the electrodiagnostic examination according to the physician reviewer.

An EMG/NCV was performed on November 6, 2008 with the following impression: "Left C5-6 radiculopathy versus proximal neuritis. Left carpal tunnel syndrome with median sensory and motor nerve entrapment across the wrist. Left Guyon canal syndrome and cubital tunnel syndrome with ulnar nerve entrapment across the wrist and elbow. Left radial neuritis across the forearm and wrist. Clinical correlation is recommended."

Records from November 21, 2008 state that the patient is having left nondominant arm pain and diffuse numbness. He stated that he is really not having neck pain. Examination findings included normal heel/toe walk, decreased cervical spine range of motion, decreased biceps and brachioradialis reflexes on the left, positive Tinel's over the ulnar nerve, negative Tinel's over the median nerve, and normal sensory exam.

The request for a cervical myelogram was again non-certified on December 2, 2008. The report states that cervical x-rays reportedly revealed C3-C6 plate and screw system with solid fusion and possibly a spontaneous fusion at C6-7. A prominent portion of the plate superiorly impinged on C2-3, causing spur formation. An EMG of November 6, 2008 was consistent with left C5-6 radiculopathy versus neuritis. Evidence for left Guyon canal and cubital tunnel entrapment of the ulnar nerve, in addition to left carpal tunnel syndrome were also noted. The report states that an October 10, 2008 cervical MRI was consistent with mild cord atrophy and C4-5 with some degree of left foraminal narrowing from C4 to C7. Examination indicated that the left biceps and brachioradialis reflexes were absent on the left. According to the physician reviewer, findings from the MRI, x-rays, and electrodiagnostic studies essentially rule out the presence of any significant cervical lesion. There is no progressive neurological deficit or red-flag neurological condition described that might require further evaluation. No new cervical surgical procedure had been contemplated. The physician reviewer stated that a myelogram CT is extremely unlikely to provide any new useful information that would change the direction of treatment.

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

According to the Official Disability Guidelines, myelograms are not recommended except for surgical planning. Myelography or CT-myelography may be useful for preoperative planning. There is no indication in the report dated November 21, 2008 that consideration has been given to a repeat cervical spine surgery.

The report does state that the patient likely needs to see an upper extremity surgeon. Given that the patient has electrodiagnostic evidence of left carpal tunnel syndrome, left Guyon canal syndrome and cubital tunnel syndrome with ulnar nerve entrapment, referral to an upper extremity surgeon would be a prudent option. Although the electrodiagnostic study also indicate C5-6 radiculopathy versus neuritis, this finding correlates with the patient's examination findings of absent biceps and brachioradialis reflexes on the left. Based on this correlation, the myelogram would likely lend no additional information. Given that the patient does not complain of neck pain, but primarily upper extremity pain and diffuse numbness, the referral to the upper extremity surgeon may help to alleviate this discomfort without the need for additional diagnostic testing regarding the cervical spine.

Therefore, my determination as to uphold the previous decision to non-certified the request for contrast x-ray of neck; injection for myelogram; CT with dye; fluoroguide for spine.

The IRO's decision is consistent with the following guidelines:

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
- X 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

Official Disability Guidelines/Chapter:

Myelography:

Not recommended except for surgical planning. Myelography or CT-myelography may be useful for preoperative planning. (Bigos, 1999) (Colorado, 2001)