



DATE OF REVIEW: 6/23/09

IRO CASE #: NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

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

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

A Texas licensed Physical Medicine and Rehabilitation provider.

REVIEW OUTCOME:

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

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> 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 CT scan of the cervical spine.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Texas Department of Insurance Fax Cover Sheet dated 6/15/09.
- Notice to, Inc. of Case Assignment Sheet dated 6/15/09.
- Notice of Assignment of Independent Review Organization sheet dated 6/15/09.
- Notice to Utilization Review Agent of Assignment of Independent Review Organization Sheet dated 6/15/09.
- Confirmation of Receipt of a Request for a Review by an Independent review Organization (IRO) Sheet dated 6/12/09.

- Request for a Review by an Independent Review Organization Form dated 6/11/09.
- Review Summary dated 5/20/09.
- Notification of Determination Summary dated 4/30/09.
- Fax Cover Sheet/Authorization Request dated 4/23/09.
- Complex Consultation Report dated 4/8/09.
- New Patient Information Sheet dated 4/8/09, 3/8/09.
- Narcotics Contract dated 4/8/09.
- Health Insurance Claim Form dated 4/8/09.
- Authorization Denial Sheet dated 4/8/09.
- Authorization Recommendation Sheet dated 4/8/09.
- Authorization Request Sheet dated 3/31/09.
- Outpatient Physician Orders Sheet dated 3/31/09.
- Consent for Treatment Sheet dated 3/9/09.
- New Patient Information Sheet dated 3/9/09.
- Pain Drawing Sheet dated 3/9/09.
- Fax Cover Sheet/Authorization Request dated 3/3/09.
- Patient Diagnosis Sheet/Authorization Request Sheet dated 3/3/09.
- Consultation Report/Letter dated 11/13/08.
- Electrodiagnostic Results Report dated 8/13/08.
- Insurance Verification Sheet dated 7/15/08.
- MRI Report dated 3/10/08
- Consent to Release Medical Records Sheet dated 4/8/09.
- IRO Decision Summary (unspecified date).

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Male

Date of Injury: xx-xx-xx

Mechanism of Injury: Involved in a motor vehicle accident.

Diagnosis: Multi-level cervical spondylosis and chronic neck pain, cervical radiculopathy of the right upper extremity.

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

The claimant is a male who sustained a work related injury on xx-xx-xx. Dr. D.C., a Pain Management provider stated that the claimant continued to stay off work and was referred to Dr. for a CT-Myelogram. On 3/10/08 an MRI of the cervical spine showed multilevel spondylosis, with moderate central spinal stenosis at C3-4 and C6-7 levels. Milder central spinal stenosis at C4-5 and C5-6 as well as moderate to severe bilateral neural foraminal stenosis at C6-7 was noted. Mild bilateral neural foraminal stenosis at C3-4 level was noted. On 11/13/08, Dr. MD, noted that he came upon cervical radiculopathy, herniated nucleus pulposus

(HNP) at C3-4 and C6-7 levels, cervical stenosis, worse at C3-4, and cervicalgia. Initiate physical therapy for symptomatic relief, evaluate for steroid therapy, a CT myelogram of the cervical spine to better evaluate foraminal and central canal stenosis. An electromyogram (EMG) report done by Dr. 8/15/08 revealed evidence of impairment to the bilateral median motor and sensory nerves at the wrists which is consistent with a diagnosis of mild bilateral carpal tunnel syndrome (right worse than left), evidence of impairment to the left ulnar motor nerve at the elbow which is consistent with a diagnosis of moderately severe left tardy ulnar palsy, and no evidence of any other focal nerve entrapment, generalized peripheral neuropathy, plexopathy, radiculopathy or central spinal stenosis. Thus, despite the right arm pain, electrodiagnostic studies did not verify that a true cervical radiculopathy was present. The ODG Guidelines for CT scanning states, *"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....For 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."* The claimant has had an MRI of the cervical spine. The ODG Guidelines do not support the need for a CT scan based on the documentation send for review. The previous determination 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.
- 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 (ODG), Treatment Index, 6th Edition (Web), 2008, Cervical-CT scan.

- 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).