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Notice of Independent Review Decision

DATE OF REVIEW: 11/19/2009

IRO CASE #:

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

This case was reviewed by a Pain Management (Board Certified), 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

Cervical myelogram with CT

REVIEW OUTCOME

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

Overturned (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Submitted medical records were reviewed in their entirety.
- Treatment guidelines were provided to the IRO.
- 10-27-05 MRI cervical spine read by Dr.
- 11-03-05 Medical report from Dr.
- 03-22-06 Operative Report - cervical fusion -from Dr.
- 08-19-06 MRI lumbar spine read by Dr.
- 01-08-08 Medical report from Dr.
- 03-14-08 Medical report from Dr.
- 07-08-09 Medical report from Dr.
- 10-23-08 Initial Consultation report from Dr
- 11-21-08 Medical report from Dr.
- 12-19-08 Medical report from Dr.
- 01-16-09 Medical report from Dr.
- 02-13-09 Medical report from Dr.
- 03-03-09 Nerve studies read by Dr.
- 03-03-09 Medical report from Dr.
- 03-20-09 Medical report from Dr.
- 04-17-09 Medical report from Dr.
- 05-15-09 Medical report from Dr.
- 05-21-09 Lab reports
- 06-12-09 Medical report from Dr.
- 07-10-09 Medical report from Dr.
- 08-07-09 Medical report from Dr.

- o 09-04-09 Medical report from Dr.
- o 10-02-09 Medical report from Dr.
- o 09-15-09 Adverse Determination Letter
- o 10-19-09 Adverse Determination Letter for reconsideration
- o 10-30-09 Request for IRO
- o 11-02-09 Confirmation of Receipt of request for IRO from TDI
- o 11-02-09 Notification of Case Assignment of IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a male who sustained an industrial injury to the cervical and lumbar spines on xx/xx/xx associated with a fall. He is status post ACDF C6-7 in 2000 and revision surgery for pseudoarthrosis on March 22, 2006 including posterior cervical fusion with instrumentation at C6-7.

Lumbar MRI of August 19, 2006 revealed no central or foraminal stenosis, no lumbar compression fracture or spondylolisthesis and a 1.0 mm bulge at L3-4 which slightly flattens the ventral surface of the thecal sac.

At examination on January 8, 2008 the patient reports snapping and popping in his neck for 1.5 months with left upper extremity pain, numbness and tingling. He was last seen in August 2007. He is 6'4" and 274 pounds and xxx. Left triceps strength is noted as 5-/5. Left C7 dermatome light touch is decreased. Cervical range of motion is full. X-rays show the hardware is in good position. He will initiate Celebrex and continue full duty and return in 6 months.

The patient was seen next on March 14, 2008. The patient reports posterior headaches and burning and stinging sensation at the back of his head over three weeks since a family member hit him in the head. His examination is unchanged. Updated x-rays show instrumentation in good position. A trigger point injection was provided.

At reevaluation of July 8, 2008 the patient reports no new problems. His former symptoms continue with left paraspinous pain, left little finger and left ring finger [numbness and tingling]. Celebrex is not helping. He is given a one-time prescription for Vicodin 5/500 mg.

The patient was provided an initial pain management consultation on October 23, 2008. He reports continuing numbness and tingling in the left arm and pain of 10/10. He continues full time work. He takes Vicodin daily after work which does help. He tried Lyrica but stated it made him forgetful. He has weakness in the left upper extremity. His weight is 304 pounds. He has significant pain with trying to lift the left upper extremity. There is decreased sensation over the left hand in the C7 distribution. He is prescribed Voltaren and Norco.

At reevaluation on November 21, 2008 the patient was noted to have 5-/5 weakness of the left triceps as well as the left wrist extensor. He continues with a high level of pain which has been helped by Voltaren and Hydrocodone at night. He does not think the Hydrocodone has been strong enough. Norco was increased to 10/325 mg.

At reevaluation on January 16, 2009 the patient complained that the Hydrocodone was not strong enough. Norco was discontinued. He would trial Percocet 5/325, four daily. On February 13, 2009 the patient reported the Percocet really did not provide as much relief as the Hydrocodone. He is getting some new tingling over the left ring finger and left small finger. He will be put back on Norco and nerve studies ordered.

Nerve studies were performed on March 3, 2009 with conclusions: There is electrical diagnostic evidence for a chronic left C6 and C7 cervical radiculopathy. There is electrical diagnostic evidence for a moderately severe left median mononeuropathy at the wrist. This is consistent with a clinical diagnosis for a left carpal tunnel syndrome. There is no electrical diagnostic evidence for a left ulnar mononeuropathy at the elbow.

Examination of March 3, 2009 showed a negative Tinel's at the wrist and elbow. There was decreased sensation over the left ring and middle finger. We will check to see if the carpal tunnel syndrome is covered under his industrial injury, otherwise he can be referred to his primary physician for this condition.

On April 17, 2009 the patient was discontinued Norco as it was not providing sufficient relief. He will initiate Oxycodone 15 mg every four hours with a two-week trial. On May 15, 2009 the patient informed that he changed his mind about Norco and wants to continue Norco. He will continue Norco (120 count prescribed) and Voltaren. As he also uses Tylenol and anti-inflammatory medication, lab work will be done. Lab work showed normal liver values with exception of AST minimally out of range at 14 (normal 15-37).

At reevaluation on June 12, 2009 the patient related he misplaced his Norco and his neck pain has increased being out of medication. He was counseled on medications and provided 120 Norco.

On July 10, 2009 the patient reported a pain level of 9/10 of neck pain and upper extremity numbness and pain. Triceps strength is 5-/5, otherwise motor strength is full. There is decreased sensation in the left C7 distribution. Norco is refilled at 120 count.

At reevaluation on August 7, 2009 the patient reports new symptoms of electric shock feelings into the right upper extremity. The examination is unchanged. On September 4, 2009 the patient also reports some right-sided numbness, over his shoulder, biceps and down past his elbow. There appears to be some decreased sensation in those areas on the right. Recommendation is for a CT myelogram.

The most current reevaluation report submitted is dated October 2, 2009. On this visit the patient is reporting increased electric shock feelings into the right side which are constant now and worsening. A CT scan has been denied and he wonders why. The pain is coming from his neck into the right shoulder and arm. Range of motion is intact but causes some pain. Spurling is negative at this point. Muscle strength is 5-/5 in the left triceps and probably 5-/5 with the right wrist extensor. There seems to be decreased sensation throughout the upper extremity on the right. He has probably new radiculopathy and previous C-7 fusion. A CT myelogram is again recommended.

Request for myelogram with CT scan was considered in review on September 15, 2009 and recommended for non-certification. A peer discussion was realized. Per ODG, plain radiographs should be the initial study performed. MRI is the test of choice for patients who have had prior surgery. Patients with normal radiographs and neurologic signs or symptoms should undergo MRI. If there is a contraindication to the MRI examination such as a cardiac pacemaker or severe claustrophobia, CT myelography, preferably using spiral technology and multiplanar reconstruction is recommended. If a patient has recent trauma, cervical tenderness and paresthesias in the hands or feet CT scan would be indicated. If the patient has recent trauma and is unconscious CT scan would be indicated. Recent trauma is a criteria, as are initial plain films, for CT scan. In peer discussion, the provider related that MRI would have compromised quality due to hardware that may produce significant artifact. The reviewer notes that it would seem appropriate to determine if a clear picture can be ascertained via electrodiagnostics before considering invasive imaging.

Request for reconsideration of myelogram with CT scan was considered in review on October 19, 2009 with recommendation for non-certification. CT was requested to evaluate the new pain complaint on the right upper extremity. A peer discussion was attempted but not realized. While examination showed muscle strength of 5-/5 on left triceps and 5/5 on the wrist with decreased sensation of the C7 distribution on the left, current guidelines do not recommend CT scan unless surgery is contemplated. Additionally, there are no reports that showed failure of conservative care such as physical therapy, exercise and medications.

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

The patient is a male who fell while loading xxx and underwent anterior cervical fusion at C6-7 and a later revision with posterior fusion at the same level. He was followed orthoepdically beginning January 2008 for left upper extremity pain, numbness and tingling. At that time, examination revealed left triceps strength of 5-/5, decreased light touch in the left C7 dermatome, full cervical range of motion. He was managed primarily with Vicodin and Celebrex. He was sent to pain management in October 2008 and has been managed there since primarily with Voltaren and Hydrocodone. He reported some new tingling over the left ring finger and left small finger and underwent nerve studies which showed chronic left C6 and C7 cervical radiculopathy and left carpal tunnel syndrome.

Since August 2009 the patient has been reporting new symptoms of electric shock feelings into the right upper extremity which have been worsening. Initially, the examination was unchanged, however, since September 2009, he reports some right-sided numbness, over his shoulder, biceps and down past his elbow and sensation appears to be somewhat decreased sensation in those areas. Range of motions remains full, Spurling's is negative at this point, muscle strength is 5-/5 in the left triceps and probably 5-/5 with the right wrist extensor. The provider requests CT scan versus MRI as artifacts may impair visualization to assess radiculopathy.

Given that the patient has had chronic left-sided radiculopathy and now more recent right-sided complaints with neurologic defcits, concern is raised with regard to either cervical radiculopathy or possible cord impingement. In this instance, imaging is appropriate, and since there is hardware in place, a CT myelogram appears to be appropriate.

Therefore, my recommendation is to disagree with the previous non-certification of the request for cervical myelogram with CT.

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

The Official Disability Guidelines - Neck and Upper Back (10-13-2009) Computed Tomography:

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) CT scan has better validity and utility in cervical trauma for high-risk or multi-injured patients. (Haldeman, 2008)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