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Notice of Independent Review Decision

DATE OF REVIEW: 11/02/09

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

CT Myelogram of the lumbar spine between 8/26/09 and 10/25/09

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.

PATIENT CLINICAL HISTORY (SUMMARY):

According to the medical records and prior reviews the patient is a female who sustained an industrial injury to the cervical spine on xx/xx/xx, when another vehicle slid on ice and struck the bus. She has been treated for neck pain that radiates to the right greater than left arm and low back pain that radiates to both feet. Her health history includes diabetes, hypertension, irregular heartbeat and a thyroid problem. She is xxx", xxx pounds and does not smoke. An initial examination of January 6, 2009 noted decreased sensation in the C6-8 dermatomes on the right. On January 7, 2009 the patient initiated tramadol, Skelaxin and Mobic.

Lumbar MRI performed January 30, 2009 was provided impression of: "1. L5-S1 central disc protrusion, diffuse disc bulge, and degenerative changes with mild to moderate left and mild right neural foraminal stenosis. 2. Mild L2-3 through L4-5 posterior annular disc bulges. 3. Mild degenerative changes of the lumbar spine, most pronounced at L5-S1 as detailed in the findings."

Cervical MRI performed January 30, 2009 showed unremarkable findings at C2-3, small disc protrusions without significant spinal canal stenosis C3-4 through C5-6 and an unremarkable study at C6-7 and C7-T1.

Bilateral upper extremity nerve studies were done on February 6, 2009 and given impression of: EMG abnormalities suggest a C4 radiculopathy on the left and a C5 radiculopathy on the right. No distal nerve pathologies were found.

The patient was examined by her current provider on February 18, 2009 for severe neck pain and low back pain. Medications include Skelaxin and tramadol. The patient is referred by her chiropractic provider. The patient reports she is unable to walk far and has a feeling of weakness in both legs. She reports a pain level of 6/10. She has attended 12 sessions of PT with benefit reported. She has not had any epidural injections. An EMG was performed but the report is not available at this visit. Her gait is normal and no muscle spasms are appreciated. Cervical range of motion is restricted. Sensation is normal. No upper extremity compression syndromes are found. She is able to heel and toe walk. Straight leg raising is negative. Lower extremity muscle strength is intact. Cervical x-rays were essentially within normal lengths without evidence for malalignment, instability, significant disc space narrowing, more than minimal degenerative changes, or any significant findings. Lumbar x-rays were essentially within normal limits with five fully developed levels without evidence of malalignment, instability, fracture, more than minimal disc space narrowing, pars defect or other significant abnormality. Diagnosis is L5-S1 disc protrusion with possible left radiculopathy, cervical soft tissue injury, small cervical protrusions without nerve compression and lumbar soft tissue injury. Recommendation is for additional conservative treatment for the cervical spine, possible epidural lumbar injections after getting cleared with her provider, lumbar therapy, future myelogram CT scan might be indicated as her low back and leg pain have not improved. Discectomy could be indicated.

The medical report of April 7, 2009 indicates right shoulder flexion of 81 degrees, extension to 32 degrees, abduction to 57 degrees and adduction to 35 degrees. A right shoulder supraspinatus tear was revealed on MRI which was planned for repair per a report of April 9, 2009. The patient underwent right shoulder surgery on May 18, 2009. On May 28, 2009 the patient was scheduled to initiate PT in 2 weeks.

The patient was examined chiropractically on July 21, 2009 post-op right shoulder surgery. Functional and other testing showed improvements in function and mood.

On July 30, 2009 the patient's orthopedist noted wonderful early result with therapy and very good chance for progressive healing. Additional PT was recommended.

The patient underwent lumbar epidural injection at L4-5 on August 5, 2009. On August 25, 2009 the patient reported little relief with the injection. Straight leg raising on the left still provokes some pain. Reflexes and sensation are normal. Ambulation is a bit guarded. She would like to proceed with a lumbar myelogram CT scan.

Request for CT myelogram was considered in review on August 31, 2009 and recommended for non-certification with rationale that the patient has had a lumbar MRI which does not appear to be limited based on the reports reviewed. She does not appear to have any hardware that would limit the interpretation of the MRI. A peer discussion was attempted but not realized. Per guidelines, MRI has largely replaced CT scanning. The rationale for a myelogram was not clarified.

On September 8, 2009 request was made for reconsideration for myelogram CT scan.

The patient was examined chiropractically on September 21, 2009. Per testing function, symptoms and mood have improved with completion of her second set of 12 sessions of post-surgical rehabilitation to the shoulder. She is referred to determine if work hardening is needed.

Per a handwritten follow-up evaluation of September 30, 2009 "MRI denied" as ordered by her orthopedic provider.

Per an orthopedic note of October 7, 2009 the patient need to continue range of motion exercises.

An Impairment Evaluation was performed on October 19, 2009. The patient is not MMI. The patient reports neck pain of 1-2/10, right shoulder pain of 4-5/10, mid and low back pain of 4-5/10 and headaches 1-2/10. Foraminal compression is positive on the right. Shoulder depression is positive on the right. Sitting left straight leg raise is positive. Shoulder flexion is 98 degrees, extension 27 degrees, abduction 70 degrees and adduction 42 degrees. Decreased sensation is noted in the C6, C7 dermatomes on the right and L5, S1 dermatomes on the left. Impression is internal derangement shoulder (post surgical), lumbar disc syndrome, lumbar radiculopathy, restricted motion, inflammation, muscle spasm, cervical sprain/strain and thoracic nerve root irritation. She is attending post surgical rehab for her right shoulder under orthopedic surgeon and seeing a separate orthopedic surgeon for her low back condition. CT myelogram has been requested. Additional surgeries could be a possibility. She has completed 4 of 6 certified psychotherapy sessions. She might require work hardening.

Request for reconsideration of CT myelogram was considered in review on September 15, 2009 and recommended for non-certification. Rational states documentation of failure of conservative treatment including PT progress notes, adequate pain medications and injections were not provided for review. Guidelines state CT ok if MRI unavailable.

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

The patient is being treated for neck and low back pain that radiate. Lumbar imaging is significant for, mild to moderate left and mild right neural foraminal stenosis. A focal neurocompressive lesion is not visualized. The patient has attended chiropractic and 12 sessions of PT (for her post-op shoulder). She reports on February 18, 2009, that she is unable to walk far and has a feeling of weakness in both legs. An EMG was performed but the results have not been reported. Objectively, in February 2009, the patient is able to heel and toe walk, straight leg raising is negative and lower extremity muscle strength is intact. Lumbar x-rays were essentially within normal limits. The impression in regard to the low back in February 2009 is, L5-S1 disc protrusion with possible left radiculopathy. Treatment during the period of March to August 2009 appears to be focused on the patient's shoulder problem. The patient reported little relief with a lumbar epidural injection on August 5, 2009. On August 25, 2009, straight leg raising on the left still provokes some pain, reflexes and sensation are normal. Conservative treatment is recommended with a possibility of injections and possible CT myelogram in the future. The impairment examination of October 19, 2009 is significant for, decreased sensation in the left L5, S1 dermatomes.

The patient's report of a feeling of weakness in both legs has not been corroborated with physical examination findings, imaging findings or nerve studies. At this time the clinical findings do not establish a medical necessity for additional imaging. Additionally, ODG notes that magnetic resonance imaging has largely replaced computed tomography scanning in the noninvasive evaluation of patients with painful myelopathy because of superior soft tissue resolution and multiplanar capability. The patient does not have any of the criteria for Myelogram/CT scanning. MRI has been available and performed without any issues. The patient does not have any metal hardware that would cause suboptimal MRI scatter or artifact. Therefore, my recommendation is to agree with the prior non-certification for CT Myelogram of the lumbar spine between 8/26/09 and 10/25/09.

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

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 - Lumbar Chapter (10-12-2009), CT and CT Myelography:

Not recommended except for indications below for CT. CT Myelography OK if MRI unavailable, contraindicated (e.g. metallic foreign body), or inconclusive. (Slebus, 1988) (Bigos, 1999) (ACR, 2000) (Airaksinen, 2006) (Chou, 2007) Magnetic resonance imaging has largely replaced computed tomography scanning in the noninvasive evaluation of patients with painful myelopathy because of superior soft tissue resolution and multiplanar capability. Invasive evaluation by means of myelography and computed tomography myelography may be supplemental when visualization of neural structures is required for surgical planning or other specific problem solving. (Seidenwurm, 2000) The new ACP/APS guideline as compared to the old AHCPA guideline is more forceful about the need to avoid specialized diagnostic imaging such as computed tomography (CT) without a clear rationale for doing so. (Shekelle, 2008) A new meta-analysis of randomized trials finds no benefit to routine lumbar imaging (radiography, MRI, or CT) for low back pain without indications of serious underlying conditions, and recommends that clinicians should refrain from routine, immediate lumbar imaging in these patients. (Chou-Lancet, 2009)

Indications for imaging -- Computed tomography:

- Thoracic spine trauma: equivocal or positive plain films, no neurological deficit
- Thoracic spine trauma: with neurological deficit
- Lumbar spine trauma: trauma, neurological deficit
- Lumbar spine trauma: seat belt (chance) fracture
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, infectious disease patient
- Evaluate pars defect not identified on plain x-rays
- Evaluate successful fusion if plain x-rays do not confirm fusion (Laasonen, 1989)