



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 11-3-09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

CT of the cervical spine

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

Board Certified in Occupational Medicine and American Board of Preventive Medicine

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- MD., office visits from 3-31-09 through 10-2-09.
- 5-13-09 MRI of the cervical spine.
- 5-17-09, MD., performed a Peer Review.
- 6-14-09 MD., provided a letter of clarification.
- 7-8-09 DO., performed a Designated Doctor Evaluation.
- 8-18-09 , MD., orthopedic surgery evaluation.
- 9-18-09 X-rays of the cervical spine.
- 9-10-09 Utilization Review was performed by DO. (report not provided).

PATIENT CLINICAL HISTORY [SUMMARY]:

Office visit with MD., on 3-31-09 notes the claimant was taken off work. The claimant was referred to physical therapy 3 x 4 and was given a diagnosis of Lumbar IVD.

MRI of the cervical spine dated 5-13-09 shows status post anterior discectomy and fusion involving the C5, C6, and C7 levels. Circumferential disc bulge at C4-C5 of approximately 2-3 mm. Flattening of the thecal sac noted. Thecal sac measures approximately 11 mm AP diameter along the midline.

On 5-17-09, MD., performed a Peer Review. He noted that the claimant had two level cervical spine fusion surgery performed on 3-3-08 by Dr. The fusion was performed with allograft bone. The claimant had been a smoker, which increases his risks of pseudoarthrosis. Dr. had not reported any confirmed healed fusion at C5-C6 or C6-C7 on the postop radiographs. The xx/xx/xx MVA was over xx months post operative of the cervical spine. The vertebral bodies that were fused were spanned by a plate. There was no report that the xx/xx/xx MVA resulted in a plate fracture or dislodgement. Thus any failure to heal the C5-C6 or C6-C7 fusion would be unrelated to the xx/xx/xx MVA.

The reviewer did not believe that there was treated needed for the cervical spine as related to the xx/xx/xx MVA.

Office visit with Dr. dated 5-22-09 notes the claimant has neck pain. His low back pain improved after surgery. On exam, the claimant had decreased range of motion. He has more pain in the mornings. The claimant was provided with a prescription for Norco and Zanaflex. The evaluator recommended pain consult.

Office visit with Dr. on 6-5-09 notes the claimant complains of neck and low back pain. There is a dispute over the cervical spine. On exam, the claimant has decreased range of motion of the cervical spine. The claimant is status post discectomy. The evaluator recommended an orthopedic consult.

On 6-14-09 MD., provided a letter of clarification. He noted that Dr. had proposed that the alleged C4-C5 3 mm disc bulge is a sequelae of the xx/xx/xx MVA, which is not validated by the records for review. The evaluator reported that the breakdown of the adjacent disc juxtaposed next to a fusion is a known and rather common occurrence given the fact that the claimant had disc abnormalities already at C4-C5 even prior to the xx/xx/xx MVA further supports this reviewers opinion that the C4-C5 degenerative changes exacerbated by the 3-3-08 fusion of C5 to C7 not the single episode of the xx/xx/xx MVA is basis for the alleged current change at C4-C5.

On 7-8-09, DO., performed a Designated Doctor Evaluation. It was his opinion that the claimant suffers from cervical disc disease. The lumbar disc disease was surgically corrected and the claimant reports he feels fine. The evaluator reported that when he reviewed the cervical x-rays from 2007 and compared them to the neck x-rays taken as a result of the second injury, there are some additional findings of the x-rays of the neck following the second injury that were not there on the first time. Those specifically were a flattening of the thecal sac secondary to a disc bulge at C4-C5. The evaluator felt that this represented a change from the previous x-ray and could be explained by the second MVA. The evaluator felt that the cervical disc disease resulted from the second MVA. There may or may not have been damage to the cervical fusion. A contrast CT scan will be needed to help make this call.

On 8-18-09, the claimant was evaluated by MD., orthopedic surgeon who reported the claimant's history is complicated by the fact that in xx/xx he was involved in a previous rear end collision, which resulted in neck and shoulder injuries. He underwent C5-C6 and C6-C7 discectomy and fusion. He also underwent bilateral shoulder arthroscopies performed on 7-12-07 on the right and on 8-22-07 on the left. The claimant was in the postoperative period from this surgery intervention when the xx/xx/xx MVA occurred. After this accident, the claimant went to Regional Hospital ER with complains of neck and back pain. He was provided with a cervical collar. He went to see the neck surgeon, who did not advise of any disruption of his cervical fusion. It was the evaluator's opinion that the claimant's cervical disc disease was present at the time of the xx/xx/xx injury. He noted that it may also be related to pseudoarthrosis of the cervical fusion at the C5-C6 level. However, the pseudoarthriis would not have been

produced by the second MVA, but rather would indicate an ordinary event of life. The claimant's hardware did not break. Further he is a cigarette smoker, which would adversely affect the healing of the cervical fusion. The evaluator felt the appropriate treatment would include over the counter analgesics or anti-inflammatory medications on a prn basis and a home exercise program. The evaluator felt the claimant had reached MMI from his low back injury. The evaluator felt the claimant should be awarded 5% for the low back injury.

Followup with Dr. on 8-21-09 notes the claimant has cervical radiculopathy and is pending CT myelogram. It is noted the claimant has severe neck pain and right shoulder pain that is progressive in nature. The evaluator requested the CT to investigate the integrity of the fusion. This is medically necessary to rule out instability/integrity.

9-18-09 X-rays of the cervical spine shows status post anterior discectomy and fusion involving the C5, C6, C7 levels. If further evaluation of hardware or fusion integrity is indicated, thin section CT scan with 1 mm images are recommended.

Followup with Dr. on 8-14-09 notes the claimant complains of neck and low back pain. The claimant is pending CT myelogram. The evaluator noted the claimant has progressive upper extremity neurological signs and symptoms. The Designated Doctor also recommended the CT with contrast. On exam, the claimant had motor testing 4/5 at right trapezius, decreased range of motion. Diagnosis: Cervical IVD.

On 9-10-09, A Utilization Review was performed by , DO. (report not provided).

Followup with Dr. on 9-18-09 notes the claimant had flexion/extension x-rays. The evaluator recommended CT myelogram. The claimant is continued at work with restrictions.

Followup with Dr. on 10-2-09 notes the claimant complains of left knee pain. The claimant is status post fall. Assessment: Left knee derangement. The evaluator recommended physical therapy and an MRI of the left knee.

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

Medical documentation notes the claimant has new x-ray changes and on physical examination, the claimant has radiculopathy. It is also noted the claimant has severe neck pain and right shoulder pain that is progressive in nature. ODG-TWC states that CT scan is indicated if there is known cervical spine trauma, equivocal or positive plain films with neurological deficit. Based on the medical documentation provided, the claimant meets the criteria for the requested CT scan of the cervical spine. Therefore, the request for a cervical CT scan is certified.

ODG-TWC, last update 10-13-09 Occupational Disorders of the Neck and Upper Back – Cervical CT scan: 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

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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)