

MATUTECH, INC.

PO BOX 310069
NEW BRAUNFELS, TX 78131
PHONE: 800-929-9078
FAX: 800-570-9544

Notice of Independent Review Decision

DATE OF REVIEW: July 28, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Myelogram CT of cervical spine (72125, 62284)

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

Certified, American Board of Orthopaedic Surgery

REVIEW OUTCOME

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Back Institute

- f* Diagnostic (03/25/10)
- f* Office Notes (02/25/09 – 06/23/10)
- f* Utilization reviews (06/14/10, 07/13/10)

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- f* Office Notes (02/25/09 – 06/23/10)
- f* Utilization reviews (05/27/10, 07/06/10)

TDI

- f* Utilization reviews (05/27/10, 07/06/10)

[ODG has been utilized for the denials.](#)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who alleges injury to her neck on xx/xx/xx, as she was lifting approximately 1.5 L bottle of unknown substance.

She was noted to have disc protrusions at C5-C6 and C6-C7 that was treated with cervical block. Post block she developed hematoma that required an emergent surgical decompression posteriorly. Approximately five months later, there was a spinous process fracture requiring additional surgery and removal.

In February 2009, she presented to M.D., for increasing neck pain with paresthesias along the entire trapezius and into the shoulders. The pain radiated down the right arm more than the left and tingling, pins and needle sensation along the back mostly in the trapezius. She utilized hydrocodone and muscle relaxants. Dr. diagnosed cervical radiculitis and unspecified idiopathic peripheral neuropathy and started her on prednisone.

In March 2010, the patient again returned to Dr. with left-sided neck pain associated with stiffness, paresthesias, muscle spasms to the neck, upper back and left upper extremity and muscular weakness. He reported the history was significant for herniated disc and treatment with epidural steroid injection (ESI). During the procedure, the patient developed a hematoma resulting in hemiparesis to the left side. She underwent surgery to correct this in 2003. Dr. started her on Medrol Dosepak and obtained magnetic resonance imaging (MRI) of the cervical spine.

MRI revealed posterior disc osteophyte complex at C4-C5 and C5-C6 effacing the ventral subarachnoid space, broad-based disc protrusion asymmetric leftward at C5-C6 projecting into the region of the left C5-C6 neural foramen and causing mild left neuroforaminal narrowing without evidence of nerve root impingement, and tiny central disc protrusion at C6-C7.

On May 19, 2010, M.D., saw the patient for significant dysesthesia and weakness of the left upper extremity with weakness in the wrist flexor and extensor function. Examination showed weakness of the left deltoid, diminished biceps function of the left upper extremity. Flexion-extension views of the cervical spine showed spondylotic disease especially at the C5-C6 area. He reviewed the MRI findings and diagnosed cervical disc protrusion at C5-C6, C6-C7 with spondylotic changes also at the C4-C5 area and the disc osteophyte complexes effacing the ventral subarachnoid space at C4-C5 and C5-C6. He requested computerized tomography (CT) myelogram for suspected neurological changes which might be permanent given the chronicity of weakness.

On May 27, 2010, the request for cervical myelogram CT was denied with the following rationale: *"I was unable to reach the provider for peer-to-peer discussion. Recommend adverse determination. It is unclear what additional information a CT myelogram will provide, given that the MRI appears to have been of adequate quality. Recommend non-approval"*.

On June 23, 2010, Dr. again placed an appeal for a CT myelogram to evaluate the level of bony stenosis certainly to explain why she had such profound weakness. He stated this was a "goal" standard to evaluate for bony foraminal stenosis and also to clearly delineate which were the worst areas of pathology and certainly if she had neurologic deficit decompressing the foramen adequately could be addressed.

On July 6, 2010, an appeal for cervical CT myelogram was denied with the following rationale: "I made two reasonable attempts to contact the provider for additional information. The medical records suggest a change in neurological status. The patient may or may not be a candidate for additional surgery. And she may be a candidate for repeat MRI scan on the basis of the change in neurological findings. In the absence of the additional information the indication for cervical myelography is not considered to be established".

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

Weakness of the deltoid, biceps, wrist and hand extensors cannot be explained by the MRI, even if the symptoms and clinical findings are progressive, as has been suggested. All the findings on the cervical MRI – including but not limited to typical degenerative and/or congenital findings (degenerative disc disease, disc desiccation, disc collapse, disc dehydration, disc narrowing, annular bulging, annular tear, HIZ, disc bulging, disc herniation, disc protrusion, degenerative facet arthrosis, osteophytes, ligamentum hypertrophy, listhesis or spondylolysis, arthropathy, spondylosis, end-plate changes, stenosis, central canal stenosis, neuroforaminal stenosis, neuroforaminal encroachment, scoliosis, curvature changes, uncovertebral degenerative changes, Schmorl's nodes, vacuum phenomenon, and bone marrow edema) – are most medically probably pre-existing and/or chronic in nature, and appear to have little or no relationship to the clinical scenario presented per the documentation. I concur with the opinions of the reviewers that there is insufficient evidence presented by the requesting provider to establish the medical necessity of a CT-myelogram, per ODG criteria.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES