

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
12001 NORTH CENTRAL EXPRESSWAY
SUITE 800
DALLAS, TEXAS 75243
(214) 750-6110
FAX (214) 750-5825

Notice of Independent Review Decision

DATE OF REVIEW: JANUARY 8, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CT scan of the cervical spine with contrast to include CPT code #72125

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

American Board of Medical Specialties, Family Practice; practice in occupational 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Medical records from the URA include:

- Official Disability Guidelines, 2009
- Rehabilitation and Occupational Medicine, 06/16/09,
- M.D., 07/30/09, 09/30/09, 10/28/09,
- 11/13/09, 12/08/09

PATIENT CLINICAL HISTORY:

The date of injury is xx/xx/xx. The type of injury is lumbar spine radiculitis. The description of services or services in dispute is CT scan of the cervical spine with contrast to include CPT code #72125. I am asked to perform a brief clinical description and the rationale for approval or denial.

I am provided with a thorough and appropriate evaluation consistent with the Occupational Disease Guidelines by M.D., occupational medicine physician. He lists the specific indications for CT tomography. These are in the 2009 ODG Guidelines, however, are much more appropriate for acute type of injuries. However, a CT scan is not recommended except for specific indications and these include suspected or known cervical trauma with or without neurological deficits. Dr. xxxxx goes on to correctly summarized recommendations in the ODG Guidelines that an "MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. MRI was the test of choice for patients who have had prior back surgery." Therefore, Dr. stated that it was his opinion based upon the clinical documentation he had that the previous cervical injury had resolved and there was no notation of any new onset focal neurological deficits or neurological changes which would be consistent with the instability of the previous surgical site.

I have a report of a required medical examination from June 16, 2009. The clinical summary is performed by, D.O. He notes that the patient previously had a decompression laminectomy at C4 to C7, with what appears to be a three-level fusion at these areas. There is notation of a bone harvest from the iliac crest consistent with a fusion. A CT cervical myelogram of July 8, 1997, revealed a C4-5 large posterior endplate osteophyte. There were similar findings at C5-6, with mild displacement of the thecal sac at that level and mild left neural foraminal narrowing. There was a large central disc herniation that deformed the thecal sac at C6-7, causing moderate spinal stenosis in the AP diameter. EMG/nerve conduction study of November 9, 1998, revealed no evidence of radiculopathy goes on to note that all imaging studies to that point have indicated a solid consolidation of the previous fusion without any notation of pseudoarthrosis.

I have evaluation by M.D., from July 30, 2009. On his neurological assessment of that date he notes a normal distal motor function and sensation to light touch. The assessment was low back pain.

On September 30, 2009, the neurological assessment revealed left hand grip and left elbow flexion to be 4/5 in strength. The assessment was cervical radiculitis. A CT scan of the spine was recommended.

In followup on October 28, 2009, there is no additional notation of these deficits of elbow flexion and grip. The neurological assessment on this date reveals normal distal motor function and sensation to light touch.

A medical review was performed by Dr. M.D., on November 13, 2009. In review of records, he notes deficiencies in cervical range of motion, breakaway weakness in the left upper extremity and no gross muscular atrophy in the upper extremity. This was from the 1998 postoperative period. An MRI on September 13, 1998, reported to reveal evidence of decompression laminectomy at C4 through C5 with no evidence of cord compression or nerve root compression. An EMG/nerve conduction study on November 9, 1998, revealed no evidence of radiculopathy. A CT myelogram on February 6, 2006, just under four years ago, reported a solid fusion of C4 through C7. According to the designated doctor's report from June 16, 2009, the patient's clinical cervical spine evaluation revealed her injury to have resolved. The effects of the injury were felt to have resolved at that point. Dr. arrives at a similar conclusion. He reviews the ODG Guidelines for CT myelogram. He further states that the latest physical examination did not clearly establish that the symptoms of the patient were directly caused by cervical spine pathology. There were no recent radiographic findings prior to the request. The rationale for requesting the CT was not specified in the report. Therefore, Dr. recommended non-certification.

There is a similar assessment by M.D. This was performed on December 3, 2009. He similarly recommended non-certification for the reasons previously elucidated.

I have no further documentation.

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

I am asked if I uphold or overturn the previous medical review decisions for adverse determination. I would have to concur with the findings of the three other physicians based upon the rationale elucidated in my report. I cannot see the necessity for a CT with contrast of the cervical spine based upon no specific findings on physical examination and no suggestion of any alteration in the status of her neck, status post a three-level fusion of C4 through C7. As the ODG Guidelines have stated, the test of choice for post surgical evaluation of the back is an MRI and a CT is not recommended, only under very specific circumstances, which I have delineated. Therefore, I uphold and agree with the previous determination.

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)