DATE OF REVIEW: 06/25/10

IRO Case #:

Description of the services in dispute:

This is a request for a cervical myelogram with CT scan for this patient.

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician who provided this review is board certified by the American Board of Neurological Surgery. This reviewer is a member of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons. The reviewer has completed training in both pediatric and adult neurosurgical care. This reviewer has been in active practice since 2001.

Review Outcome

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

Based on ODG guidelines, the request for a cervical myelogram with CT scan is not medically necessary for this patient.

Information provided to the IRO for review

Records Received from the State:

Confirmation of Receipt of a request for a Review by an Independent Review Organization (IRO), 06/14/10 (4 pages)

Request for a Review by an Independent Review organization, 06/09/10 (2 pages)

xxxx, prior review, 06/04/10 (4 pages)

xxxx, prior review, 05/18/10 (4 pages)

Records Received from URA:

, DC, Clinic note, 05/24/10 (1 page)

, DC, Clinic note, 05/10/10 (2 pages)

, DC, Patient personal medical history, 05/10/10 (1 page)

xxxxx, Clinic note, 05/06/10 (1 page) Date grid, 05/06/10 (3 pages)

xxxxxx, MRI report, 04/23/10 (2 pages)

xxxx, MRI report, 04/23/10 (2 pages)
xxxx, Clinic note, 04/22/10 (1 page)
xxxx, Clinic note, 04/20/10 (1 page) Date grid, 04/20/10
and 04/22/10 (3 pages)
xxxx, Clinic note, 04/15/10 (1 page) Date grid, 04/12/10
and 04/15/10 (3 pages)
Evaluation summary, Functional capacity evaluation, 03/30/10 (11 pages)
Clinic note, 03/25/10 (1 page)
xxxx, physical therapy note, 01/26/10 (1 page)
xxxx, CT report, 01/13/10 (2 pages) Records
Received from Carrier:
Law Offices, Carrier submission, 06/17/10 (7 pages)
Clinic note, 05/25/10 (2 pages)
Clinic note, 04/27/10 (2 pages)
xxxx, Clinic note, 04/12/10 (1 page)
xxxx status report, 04/09/10 (1 page)
xxxx, 04/09/10 (1 page) Questionnaire,
undated (1 page)
Heath History, 02/05/09 (2 pages)
General Physical Examination, 03/25/10 (1 page)
xxxx Clinic note, 02/05/10 (1 page)
xxxx status report, 02/05/10 (1 page) CT report, 01/13/10 (1 page)
Clinic note from, MD, 01/08/10 (1 page)
xxxxstatus report, 01/08/10 (1 page) Clinic note from, MD, 12/31/09
(1 page)
xxxx, X-ray report, 01/04/10 (1 page)
xxxx, X-ray report, 12/31/09 (1 page)
xxxx, Clinic note, 12/31/09 (1 page) ODG guidelines, Neck and
Upper Back Chapter (178 pages)
ODG guidelines, Pain chapter (382 pages)

Patient clinical history [summary]

The patient is a female who sustained an injury on xx/xx/xx when she fell backwards out of her desk chair. The patient was evaluated by Dr on xxxxx. She states she was leaning back in her desk chair when she fell over backwards. She denies loss of consciousness or head injury. She reports stiff neck and low back pain. She states the low back pain radiates down the back of her leg. Physical exam reveals full range of motion of the neck. There is tenderness primarily in the erector spinae muscle group in her cervical and trapezius area. There is tenderness over the erector

spinae muscle group of the cervical and lumbar area. The patient is assessed with neck sprain, low back pain with radiculopathy, and muscle spasm. She is prescribed prednisone and methocarbamol. Radiographs of the cervical spine performed 12/31/09 demonstrate somewhat limited views of the odontoid and lateral masses. No definite acute fractures or dislocations are noted. Radiographs of the lumbar spine performed 12/31/09 demonstrate no plain film evidence of acute fractures or dislocations. The patient returned to Dr. on 01/08/10 with continued pain complaints. Physical exam reveals low back pain with tender muscles and spasm. There is also severe pain at L5-S1. She complains of pain radiating into both buttocks and legs. The patient is recommended for CT of the lumbar spine and physical therapy. CT of the lumbar spine performed 01/13/10 demonstrates essentially negative findings with very mild multilevel degenerative disc disease changes and facet arthrosis. There is no significant canal stenosis or neural foraminal stenosis identified. There are no compression fractures noted. A Functional Capacity Evaluation was performed on 03/30/10. The patient's occupation requires a sedentary/light physical demand level. The patient demonstrated the ability to perform at a sedentary/light physical demand level. The patient rated her pain at 7 to 8 out of 10 on the VAS scale after testing. The patient is recommended to continue active therapy.

The patient was seen in a xxxx on xxxx with complaints of low back and neck spasms. Physical exam reveals tenderness at C3-6 and L4-S1. Cervical range of motion is limited. The patient is prescribed Naproxen 500mg, Flexeril 10mg, and Lortab 7.5mg. The patient is recommended for MRI of the neck. MRI of the cervical spine performed 04/23/10 demonstrates mild degenerative anterolisthesis of C4 on C5. There is moderate left C4-5 foraminal stenosis; impingement of the exiting left C5 nerve root is not excluded. There is a posterior annular fissure/tear and small central disc protrusion at C5-6 partially effacing the ventral subarachnoid space and minimally indenting the ventral cord contour. There is no spinal stenosis. A letter by Dr. dated 05/10/10 states the patient complains of significant neck and low back pain. Current medications include soma, naproxen, and hydrocodone. She has undergone extensive physical and chiropractic therapy with no improvement. She reports posterior cervical and interscapular pain with bilateral radiating shoulder and arm pain, particularly on the right side. The lumbar pain radiates into both legs equally. Physical exam reveals paracervical muscular tightness and some loss of cervical lordosis. There is decreased range of motion of the low back with paralumbar muscular tightness. There is tenderness over both sciatic outlets. There is scattered sensory loss in the C5 and C6 dermatomes bilaterally. She is able to stand on her toes and heels. Straight leg raise at 60 degrees causes low back pain and posterior thigh pain. The patient is recommended for cervical and lumbar myelography and CT scanning. The request or CT myelography was denied by utilization review on 05/18/10 by Dr.. Dr. opined that there was no indication that the patient was a surgical candidate. A letter by Dr. dated 05/24/10 states the patient is currently working light duty, but may need to quit her job. She is unable to take her medications at work, but the pain prevents her from working. She is again recommended for cervical and lumbar myelography and CT

scanning. The request for CT myelography was again denied by utilization review on 06/04/10 by Dr.. Dr. also opined that CT studies were not indicated, as the patient was not a surgical candidate.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

Based on the clinical documentation provided for review the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

Official Disability Guidelines, Online Version, Neck and Upper Back Chapter
Computed tomography (CT)
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