

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 07/12/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: MRI of cervical spine, EMG/NCV of the left upper extremity, bone mineral density test and total bone scan, as outpatient, cervical spine.

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

Texas Board Certified Orthopedic Surgeon

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. 03/13/95 - MRI Cervical Spine
2. 03/21/95 - Cervical Myelogram
3. 04/03/95 - Electrodiagnostic Studies
4. 05/12/95 - MRI Left Shoulder
5. 05/24/95 - Operative Report
6. 06/12/95 - Clinical Note -, MD
7. 06/21/95 - Addendum Letter - , MD
8. 07/07/95 - Clinical Note -, MD
9. 07/10/95 - Clinical Note -, MD
10. 08/23/95 - MRI Cervical Spine
11. 10/10/95 - Radiographs Lumbar Spine
12. 10/10/95 - MRI Lumbar Spine
13. 12/01/95 - Clinical Note - MD
14. 12/22/95 - Radiographs Cervical Spine
15. 01/05/96 - Clinical Note -, MD
16. 01/05/96 - Radiographs Dorsal Spine
17. 01/05/96 - Radiographs Lumbar Spine
18. 01/23/96 - Operative Report
19. 05/01/96 - Radiographs Cervical Spine

20.05/08/96 - Clinical Note -, MD
21.05/20/96 - Electrodiagnostic Studies
22.06/10/96 - Clinical Note -, MD
23.06/13/96 - Physical Therapy
24.07/31/96 - Clinical Note -, MD
25.08/19/96 - MRI Cervical Spine
26.08/23/96 - Clinical Note -, MD
27.09/20/96 - Clinical Note -, MD
28.09/28/96 - MRI Lumbar Spine
29.10/08/96 - Bone Densitometry
30.10/16/96 - Impairment Rating
31.10/20/97 - Arthrogram Right Shoulder
32.12/01/97 - Myelogram Lumbar, Cervical, and Thoracic
33.05/27/98 - CT Cervical Spine Post Myelogram
34.08/03/00 - MRI Cervical Spine
35.02/19/03 - Operative Report
36.11/19/03 - MRI Cervical Spine
37.03/31/05 - Clinical Note -, MD
38.07/22/05 - Clinical Note -, MD
39.10/27/05 - Clinical Note -, MD
40.01/27/06 - Clinical Note -, MD
41.04/27/06 - Clinical Note -, MD
42.08/02/06 - Clinical Note -, MD
43.11/01/06 - Clinical Note -, MD
44.12/13/06 - Clinical Note -, MD
45.03/02/07 - Clinical Note -, MD
46.06/06/07 - Clinical Note -, MD
47.09/19/07 - Clinical Note -, MD
48.10/17/07 - MRI Cervical Spine
49.12/26/07 - Clinical Note -, MD
50.03/26/08 - Clinical Note -, MD
51.04/23/08 - Clinical Note -, MD
52.06/18/08 - Clinical Note -, MD
53.07/28/08 - Clinical Note -, RN, FNP
54.10/30/08 - Clinical Note - MD
55.01/29/08 - Clinical Note -, MD
56.04/24/09 - Clinical Note -, MD
57.09/03/09 - Clinical Note -, MD
58.12/02/09 - Clinical Note -, MD
59.03/26/10 - Clinical Note -, MD
60.03/31/10 - Clinical Note - , MD
61.04/14/10 - MRI Left Shoulder
62.05/07/10 - Procedure Note
63.05/24/10 - Clinical Note -, MD
64.06/24/10 - Clinical Note -, MD
65. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a female who sustained an injury when she lifted a file cabinet overhead.

An MRI of the cervical spine performed 03/13/95 demonstrated evidence of cervical disc disease at C5-C6 with spondylitic features of a bulging degenerative and partially herniated central disc impressing on the thecal sac anteriorly, and at least touching, if not displacing, the spinal cord posteriorly with findings of at least mild canal stenosis.

A cervical myelogram performed 03/21/95 demonstrated small ventral extradural defects at C4-C5 and C5-C6 caused by posterior osteophytes.

Electrodiagnostic studies performed 04/03/95 demonstrated normal nerve conduction studies. On the right, there was abnormal spontaneous activity in the form of positive waves in several right C6 innervated muscles.

An MRI of the left shoulder performed 05/12/95 demonstrated large osteophytes at the acromioclavicular joint with impingement. There was an abnormal signal in the supraspinatus muscle and tendon, suggestive of injury and possible partial tear. A full-thickness tear could not be excluded, although there was no abnormal fluid collection seen in the subacromial or subdeltoid bursas to suggest this.

The employee underwent arthroscopy of the glenohumeral joint, debridement of the rotator cuff, arthroscopy of the subacromial space, and subacromial decompression on 05/24/95.

The employee was seen by Dr. on 06/12/95. The employee stated her primary pain was in the neck with radiation down the right arm to the right elbow. The employee reported tingling and numbness in the right ulnar three digits. The physical examination revealed tenderness over the paracervical muscles. There was decreased range of motion of the neck in flexion, extension, and rotation. There was full range of motion of the shoulders, elbows, and hands. Radiographs of the cervical spine revealed no fracture or dislocation. There was spondylosis at C5-C6 and C6-C7. The employee was assessed with cervical strain with radiculopathy. The employee was recommended for physical therapy.

An MRI of the cervical spine performed 08/23/95 demonstrated a moderate degree of central disc bulging or herniation at C5-C6 producing a mild to moderate spinal stenosis. Similar changes were noted at C6-C7, although somewhat less severe.

Radiographs of the lumbar spine performed 10/10/95 demonstrated minimal lumbar spondylosis. An MRI of the lumbar spine performed 10/10/95

demonstrated a small central disc protrusion at L5-S1 and anterior disc bulges at L2-L3 and L3-L4.

Radiographs of the dorsal spine performed 01/05/96 demonstrated degenerative changes. Radiographs of the lumbar spine performed 01/05/96 demonstrated degenerative changes, most prominent at L4-L5. The employee underwent anterior cervical discectomy and anterior fusion at C5-C6 and C6-C7 with anterior instrumentation from C4 to C6 on 01/23/96.

Electrodiagnostic studies performed 05/20/96 demonstrated possible S1 radiculopathy and possible L4 radiculopathy bilaterally.

An MRI of the cervical spine performed 08/19/96 demonstrated a mild central disc bulging at C4-C5. There was increased fluid in facet joint at C5-C6 bilaterally, probably representing degenerative changes.

An MRI of the lumbar spine performed 09/28/96 demonstrated mild degenerative changes.

Bone densitometry performed 10/08/96 demonstrates normal bone mass of the left hip and lumbar spine.

The employee underwent an impairment rating for the cervical spine and left shoulder on 10/16/96. The employee was assigned a 25% whole person impairment.

A right shoulder arthrogram performed 10/20/97 demonstrated a partial tear of the rotator cuff.

Lumbar, cervical, and thoracic myelogram performed 12/01/97 demonstrated mild ventral extradural defects at C4-C5, C5-C6, and C6-C7, most likely caused by bulging discs. There was a mild ventral extradural defect at L4-L5, most likely caused by a mildly bulging disc. A CT of the cervical spine post myelogram performed 12/01/97 demonstrated evidence of fusion from C5 to C7 with the presence of hardware and small spondylotic changes and minimal bulging of the disc at C4-C5.

An MRI of the cervical spine performed 07/31/00 demonstrated moderate protrusion of the disc at C4-C5 and anterolisthesis. There was no compression of the spinal cord. There was mild protrusion of the disc at C3-C4.

The employee underwent rotator cuff repair and subacromial decompression of the right shoulder on 02/19/03.

An MRI of the cervical spine performed 11/19/03 demonstrated status post anterior cervical fusion from C5 to C7 in excellent condition. There was mild

spondylosis/disc bulge at C4-C5 without evidence of compression of the spinal cord or the neuroforamina.

An MRI of the cervical spine performed 10/17/07 demonstrated disc bulging at C4-C5 with hypertrophic changes posteriorly at C4-C5. No definite focal disc herniation was noted.

The employee returned to Dr. on 03/31/10 with complaints of gradually worsening shoulder pain. The pain was posterior to the shoulder and radiated into the anterior chest well into the pectoralis muscle. She denied numbness or tingling in the hand. She had tried a TENS unit and a cortisone injection with no relief. Physical examination revealed mildly positive impingement sign. There was weakness with abduction. Neer and Hawkins tests were slightly positive. The employee was recommended for an MRI of the left shoulder.

An MRI of the left shoulder performed 04/14/10 demonstrated changes of tendinosis in the distal supraspinatus tendon and changes of bursitis. Postoperative changes were seen, but not definite evidence of complete thickness rotator cuff tear was identified. There were degenerative changes of the acromioclavicular joint.

The employee received a steroid injection to the left shoulder into the subacromial bursa on 05/07/10.

The employee was seen by Dr. on 05/24/10 with complaints of left shoulder pain. The employee reported no significant relief from the injection. The employee stated the pain radiated into the left upper arm and across to the left sternum. She rated her pain at 7 out of 10 on the visual analog scale. She reported numbness and tingling in all five digits. The physical examination revealed a positive Spurling's on the left. There was tenderness in the neck. There was generalized weakness, but no focal motor deficits. There was full range of motion of the neck with flexion, extension, and rotation. Radiographs of the neck revealed a solid fusion at C5, C6, and C7. There were adjacent level diseases at C4-C5 and C7-T1. The employee was assessed with cervical radiculopathy, chronic neck and arm pain, bursitis of the left shoulder, and osteopenia. The employee was recommended for EMG of the left upper extremity, MRI of the cervical spine, a total bone scan, and a bone densitometry.

A request for a cervical MRI, EMG/NCV of the left upper extremity, bone mineral density, and total body bone scan was denied on 06/04/10 because of no indication of significant neurological deficit involving the left upper extremity and no indication for a total body bone scan.

The employee was seen by Dr. on 06/24/10 with complaints of neck and bilateral shoulder pain. She complained of chronic and recurrent sharp, aching, burning, and throbbing neck, and bilateral shoulder pain with radiation into the left arm.

She rated her pain at 5 out of 10 on the visual analog scale, mainly in the left shoulder. She reported shocking pain into both scapulas with movement of her head and recurrent headaches. She reported bilateral arm and hand numbness with tingling and weakness in the left arm. The physical examination revealed limited range of motion of the shoulders and pain to palpation. Examination of the cervical spine revealed limited flexion, extension, rotation, and lateral tilting. Range of motion did reproduce radiculopathic symptoms. There was tenderness and spasm to palpation. Examination of the thoracic spine was unremarkable. Examination of the lumbar spine revealed limited range of motion with flexion, extension, and lateral tilting. There was tenderness and spasm to palpation. The employee was assessed with cervical postlaminectomy syndrome. The employee was prescribed Medrol Dosepak, Lyrica, Amitriptyline, Zanaflex, Celebrex, and Nexium.

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

The clinical documentation provided for review does not support the requested diagnostic testing. Radiographic studies demonstrate a successfully fused construct in the cervical spine with no evidence of pseudoarthrosis or hardware failure that would reasonably require additional imaging or bone scans. There is also no evidence of a progressive or severe neurologic deficit as recommended by current evidence based guidelines. EMG/NCV studies are not indicated as it is unclear from the clinical notes whether additional electrodiagnostic studies would provide any additional information that would significantly guide the employee's current treatment.

As such, the prior denials for the requests 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 and Pain Chapters.