

# MATUTECH, INC.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** November 8, 2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Cervical myelogram with CT.

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

Diplomat, American Board of Orthopaedic Surgery  
Fellowship trained in spine surgery

**REVIEW OUTCOME**

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

Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**i:**

- Office notes (09/08/08 – 08/23/10)
- Diagnostics (07/10/08 – 06/21/10)
- Operative notes (09/24/08)

**Dr.:**

- Office visits (06/23/08 – 09/27/10)
- Diagnostics (07/10/08 – 06/21/10)
- Rehabilitation (07/09/10 – 07/19/10)
- Procedures (08/08/08 – 09/24/08)
  
- Office visits (06/23/08 – 09/27/10)
- Diagnostics (04/15/08 – 06/21/10)
- Procedures (08/08/08 – 09/24/08)
- Rehabilitation (08/14/10 – 07/19/10)
- Reviews (06/12/09 – 04/05/10)

**Dr.**

- Diagnostics (04/15/08)
- Office visits (05/09/08 – 09/27/10)
- Procedures (09/24/08)
- Reviews (06/12/09 – 06/02/10)
- Utilization reviews (06/09/10 – 07/07/10)
- Rehabilitation (06/14/10 – 08/10/10)

**ODG has been utilized for the denials.**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who sustained a work related injury on xx/xx/xx. She lifted a casket overhead along with a coworker and it wobbled. She caught it in an awkward position and had onset of neck pain radiating into the right trapezius and right shoulder pain down to the arm.

**2008:** The patient was initially evaluated at Hospital. X-rays of the cervical spine showed minor degenerative disc disease (DDD) at the C5-C6 level. Magnetic resonance imaging (MRI) of the right shoulder demonstrated prominent tendinopathy of the supraspinatus and infraspinatus tendons without a frank tear.

On May 9, 2008, M.D., saw the patient for right shoulder pain and administered a steroid injection for right shoulder rotator cuff syndrome.

Neurosurgeon M.D., noted some benefit from the injection. On examination, the patient tended to keep her head and neck slightly flexed. Lateral bending reproduced pain into the right shoulder. There was decreased mobility of the neck in all directions and paracervical muscular tightness with some loss of lordosis. There was discomfort with right shoulder motion and generalized weakness in the right upper extremity with depressed reflexes.

A cervical MRI showed multilevel spondylitic change with the most prominent findings at C5-C-6 with some unciniate hypertrophy, bilateral neuroforaminal narrowing (mild on the left and mild-to-moderate on the right). The patient received an epidural steroid injection (ESI) at right C5-C6.

The patient was seen in the emergency room (ER) on August 21, 2008, for increased pain in neck, dizziness and lightheadedness. She was treated with injections of Toradol and Solu-Medrol and given prescription for Lortab and Flexeril.

On September 24, 2008, the patient underwent an anterior discectomy at C5-C6 with C6 root decompression and excision of herniated disc; interbody fusion at C5-C6, placement of machine cage allograft interbody at C5-C6, morselized allograft interbody at C5-C6 and application of anterior plate at C5-C6. Postoperatively, the patient developed inflammation of the anterior cervical sutures but later completely healed. She was placed on Medrol Dosepak, hydrocodone and Neurontin.

**2009:** The patient had excellent relief of neck pain and bilateral shoulder and arm pain, but then developed right carpal tunnel syndrome (CTS) and wished to

proceed with surgery. Dr. felt that the CTS was not severe enough to require surgery.

On June 12, 2009 M.D., a designated doctor, assessed clinical maximum medical improvement (MMI) as of June 8, 2009, and assigned whole person impairment (WPI) of 5%.

On August 6, 2009, Dr. noted the patient had made complete recovery and was working full-time. She was not taking any analgesics.

On August 21, 2009, the patient was again seen at Hospital for neck pain and headaches and was treated with Lortab and Flexeril and heat and ice application to the affected area.

**2010:** M.D., performed a peer review and opined as follows: (1) Ongoing right shoulder complaints appeared to be related at least in part to the work injury. (2) It appeared that the treatment rendered as outlined was related to the work site event. (3) The cervical surgery appeared to have progressed along the usual timeline. The treatment certainly focused on the cervical region and it appeared that the shoulder complaints were again at the forefront, as suggested by the DD. Assuming that there was documentation that conservative care for the shoulder had failed including physical therapy (PT), subacromial injection, anti-inflammatories and activity modification, then surgery in all likelihood would be considered medically necessary. (4) It was quite probable that the right shoulder surgery could be considered reasonable and necessary. However, further documentation would be needed to ascertain the failure of conservative care.

An IRO upheld the previous non-certification for right shoulder arthroscopy with subacromial decompression.

From June 14, 2010, through July 19, 2010, the patient attended seven sessions of PT sessions consisting of manual therapy, mechanical traction and therapeutic exercises to the shoulder.

Dr. opined that the patient would also need PT to her neck. He added Motrin and Ultram.

MRI of the cervical spine revealed a postoperative cervical spine with multilevel spondylotic changes. The findings at C5-C6 were uncertain as to the amount of residual disc material at this level. There was posterior osteophyte and possibly disc osteophyte complex which was broad-based narrowing the anterior subarachnoid space. There appeared to be some mild cord contact. There was some asymmetry and more prominent findings in the right paramedian location with more prominent susceptibility artifact seen at this level. There appeared to be some cord contact and mild cord deformity in the right paramedian location. There was overall at least mild central spinal narrowing and some uncinat hypertrophy with mild right and mild-to-moderate left neural foraminal stenosis at C5-C6. The radiologist stated that the findings at C5-C6 might be later evaluated using post-myelogram computerized tomography (CT) scan of the cervical spine.

Dr. reviewed the MRI and noted that there was nothing significant at other levels other than C5-C6 and agreed with the opinion of the radiologist of obtaining a myelogram and post myelogram CT.

On September 17, 2010, the request for outpatient cervical myelogram post CT scan was denied by the carrier with the following rationale by, M.D.: *"The patient was injured in xxxx while lifting a heavy box. Request is for cervical myelogram and CT. Last visit showed the injured worker with recent MR showing foraminal and lateral recess stenosis at C5-C6 with mild cord contact but no cord. Injured worker has weakness in right biceps and decreased sensation C6 compression. No surgery is mentioned. ODG only supports the request for pre-surgical planning. Therefore the case does not meet the criteria and the request is not approved."*

On September 27, 2010, Dr. stated that the patient had severe neck pain and radicular pain down the right arm in the C6 and sometimes C7 dermatomes with numbness, dysesthesias and a feeling of weakness. She had depressed right biceps reflex with decreased sensation mainly in the right C6 dermatomes. The MRI was positive and the patient was likely to need surgery for root decompression and a myelogram CT was necessary for pre-surgical planning. He therefore placed an appeal for the same.

On October 8, 2010, the appeal for outpatient cervical myelogram with post CT scan was non-authorized with the following rationale: *"Dr. evaluated the claimant. The documentation is not sufficient and does not contain a clear description of the claimant's symptoms and pain generators. He noted that the claimant had a shoulder problem and may require surgery. He also noted that the claimant was experiencing neck pain with bilateral radicular arm pain, worse on the right, with numbness and dysesthesias in both arms. The documents reviewed also do not contain comprehensive physical or neurological examinations. The neurologic exam performed noted that the claimant "shows right upper extremity diffuse weakness and diminished sensation in the upper extremities". Reduced range of motion (ROM) was noted in the right shoulder. X-rays show an interbody fusion performed at the L4-L5 with a solid fusion. There was no other pathology identified." An MRI was performed on August 17, 2010, which revealed degenerative changes throughout the multiple levels in the cervical spine and at the C5-C6 level changes and artifacts secondary to the previous surgery were noted. There was no indications that there was any protrusion of the disc, there was some neuro foramina, some stenosis; recommended a CAT scan and myelogram to better visualize the C5-C6 level. The last office notes are extremely limited and there is no indication of any true pain radiation as well as minimal neurological examinations. The notes indicate that there is possible diminished distribution of the nerve root. The claimant describes his pain being bilateral, pain in the shoulder and neck. Comprehensive physical and neurological examinations are essential as recommended by the ODG prior to having any further diagnostic studies. The claimant also has not received proper conservative management and the possible generatives have not been identified. Conservative management and identification of the claimant's pain generators must be completed prior to any invasive procedure or any further tests being recommended."*

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

The patient is a lady who had a work injury on xx/xx/xx. She was helping a coworker and was lifting overhead when she noted onset of neck and right shoulder discomfort. She subsequently had evaluation with Dr. who noted a shoulder rotator cuff syndrome and gave her a steroid injection. She was subsequently evaluated by Dr. who noted that she had cervical symptoms with also some weakness into the right upper extremity and paracervical muscular tightness. An MRI was subsequently ordered.

The cervical MRI showed cervical neuroforaminal narrowing right greater than left with spondylosis at C5-C6. The patient had symptoms into the right upper extremity. She had subsequent cervical epidural steroid injection which did not provide any significant relief.

The patient subsequently went to the emergency room on August 21, 2008, with continued neck pain, dizziness, and light headedness. She was given prescriptions for Lortab and Flexeril.

On September 24, 2008, Dr. performed an anterior disc excision at C5-C6 with C6 root decompression. Allograft was utilized at C5-C6 with autograft as well. Anterior plate fixation was performed.

The patient then appeared to make a relatively uncomplicated recovery and was placed at maximum medical improvement by Dr. designated doctor on June 8, 2009, with 5% impairment rating.

The patient had returned to a full-time work as noted by Dr. on August 6, 2009 and was off of analgesics.

On August 21, 2009, Ms. presented to the Hospital with neck pain, headaches and was again treated with Lortab and Flexeril.

A peer review was performed by Dr. who concluded that the shoulder area discomfort was likely ongoing from the work incident. He considered the aspect of shoulder interventions to be reasonable and necessary. However, an IRO non-certified the right shoulder arthroscopy and subacromial decompression.

The patient did undergo therapy for the shoulder, but they deferred at the Rehabilitation Center on the therapy for the neck until further cervical MRI was completed. This was done on August 17, 2010, and read by Dr. who had read the previous MRI. He noted that there was some canal narrowing centrally at C4-C5 with broad-based disc osteophyte complex. However, there was no definite cord contact. The patient's C5-C6 level was more difficult to assess because of the metallic susceptibility artifact. The report indicates that there may be some mild cord contact. There was also noted still posterior osteophyte and some disc osteophyte complex. There was also at least mild central spinal narrowing and it appeared to be worse in the right paramedian location. Dr. proposed that post myelogram CT would be warranted if the patient was having symptoms commensurate with these abnormalities.

On August 23, 2010, Dr. stated that there was a need for a myelogram CT scan for her depressed biceps reflex but also decreased sensation into the right C6 dermatome. However, on utilization review the request was denied as it was not considered to be necessary for presurgical planning on one review and then the second review indicated that the patient's pain generator had not been adequately identified.

The patient does appear to have recurrent symptoms into the upper extremity. There is a note in the Rehabilitation Center's records that she has even having numbness and tingling into the fourth and fifth digits. This is not a classic C6 distribution. However, there is no apparent indication that she has cubital tunnel given the records that we have.

Given the artifact associated with the cervical spine plate fixation and the MRI suggesting that there is residual posterior osteophyte and some potential impingement towards the cord, the only way to analyze that more adequately would be with the myelogram CT scan.

Recommendation: Overturn the denial of the myelogram CT scan to provide definitive look at the cervical spinal canal anatomy.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES