CASEREVIEW

505 N. Sam Houston Pkwy E., Suite 200
Houston, TX 77060

Phone: 832-260-0439
Fax: 832-448-9314

Notice of Independent Review Decision

DATE OF REVIEW: JULY 6, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical Myelogram/cat scan (72125).

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

This physician is a Board Certified Orthopedic Surgeon with over 40 years of experience.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

September 17, 2004: MRI of the cervical spine without contrast revealed: Surgical changes with no acute findings (an anterior fusion plate placed at C5-C6) as interpreted by MD.

January 22, 2008: The claimant was evaluated at Center by MD for chronic nerve pain and cervical post-laminectomy syndrome, functioning well on Avinza, with recurrent right trapezius myofascial pain, helped in the past with trigger point injections. Physical examination revealed upper extremity motor 4/5 right grip and APE; 5/5 in other areas. Sensory – normal pinprick. Reflexes were 1+/4. The neck shows a well-healed anterior surgical scar with no swelling, ecchymosis, deformity, heat or redness. There is some right parascapular discomfort, and several trigger points are noted. No masses or spasms. Dr. plan was trigger point injection of the right trapezius and to refill the Avinza.

April 22, 2008: The claimant was re-evaluated by MD who found on physical examination tenderness in the suprascapular trapezius on the right, as well as in the mid medial scapular trapezius area, going superiorly around the border of the scapula. Several trigger points were noted. Dr. I injected each of the eight trigger points in the right trapezius, around the medial border of the trapezius in the superior cervicothroacic and suprascapular trapezius areas. She was also given samples of Skelaxin.

July 22, 2008: The claimant was re-evaluated by MD who found no changes on physical examination. He injected each of the two trigger points in the right trapezius in the upper medial border of the scapula. He also refilled her Avinza 60 mg and instructed her to continue taking Skelaxin.

November 6, 2008: The claimant was re-evaluated by MD who found no changes on physical examination. He injected each of the two trigger points in the right trapezius. She is to continue Avinza 60 mg and Skelaxin as needed.

February 5, 2009: The claimant was re-evaluated by MD who found right paracervical tenderness at around the C6-C7 level on physical examination. He refilled her Avinza prescription and recommended trigger point injections.

February 17, 2009: The claimant was re-evaluated by MD who injected each of the five suprascapular and parascapular trigger points.

May 7, 2009: The claimant was re-evaluated by MD who on physical examination found tenderness in the right paracervical and suprascapular areas, going up into the occiput with definite occipital tenderness. No masses or spasms noted. He recommended right occipital block under fluoroscopy, continue Avinza and Skelaxin, and use Lidoderm patches for home use.

June 8, 2009: MD performed a right occipital block.

June 30, 2009: The claimant was re-evaluated by MD who noted she received excellent relief from the occipital block. On physical examination he found some tenderness in the right suprascapular trapezius and tenderness in the right occipital region which is less than noted on her exam prior to the occipital block. He recommended repeating the occipital block.

July 8, 2009: MD performed a right occipital block.

August 6, 2009: The claimant was re-evaluated by MD who noted the occipital block significantly helper her pain in the right occipital area and in the suprascapular trapezius area and neck. On physical examination he found no tenderness. He refilled her Avinza.

November 5, 2009: The claimant was re-evaluated by MD who found on physical examination tenderness in the suprascapular trapezius on the right at the cervicothoracic junction with several tender areas on palpation. He injected each of the three trigger points in the right trapezius.

February 18, 2010: The claimant was re-evaluated by MD who noted that while washing her car last month, she noted paresthesias, which were painful and somewhat itchy in the right upper extremity coming from the neck. This has gotten better, but she still has numbness in the right upper extremity. On physical examination motor was 4/5 on right grip, APB, intrinsic; other areas 5/5, sensory was normal to pinprick, and reflexes were 1+/4. There was mild discomfort in the right suprascapular trapezius without masses or spasms. Dr. recommended x-rays and a MRI of the cervical spine.

February 24, 2010: MRI of the cervical spine without contrast revealed: C6-7 mild broad based disk bulge, minimally effacing the ventral thecal sac and surgical changed at C5-6. Interpreted by, MD.

February 24, 2010: X-rays of the cervical spine revealed surgical changes C5-6 with intact hardware. Alignment is anatomic. Interpreted by MD.

March 4, 2010: The claimant was re-evaluated by MD who found on physical examination motor was 4/5 right grip; APB and intrinsic were 4+/5. Elbow extension was 4/5. Sensory was slightly decreased to pinprick in the volar mid right hand, otherwise intact. Reflexes were 1+/4. There was mild discomfort in the suprascapular trapezius on the right without masses or spasms. He recommended a cervical epidural steroid injection.

June 15, 2010: The claimant was re-evaluated by MD who found no changes on physical examination. He continues to recommend the cervical epidural steroid injection that has yet to be approved.

June 28, 2010: MD performs a cervical epidural steroid injection.

August 19, 2010: The claimant was re-evaluated by MD who noted the ESI helped for a month, but the pain is coming back. On physical examination motor was 4/5 right grip; APB and intrinsic. Elbow extension was 4/5. Sensory was slightly decreased to pinprick in the volar mid right hand, otherwise intact. Reflexes were 1+/4. There was discomfort in the right suprascapular and paracervical trapezius on the right without masses or spasms. He would like to repeat a cervical epidural steroid injection.

September 10, 2010: MD performs a cervical epidural steroid injection.

September 23, 2010: The claimant was re-evaluated by MD who noted the ESI did not help her. No changes on physical examination. Dr. referred her to Dr. a neurosurgeon. He also ordered a right upper extremity electrodiagnostic study. She was given a prescription for Tramadol 50 mg.

November 3, 2010: The claimant was evaluated by MD for MD who found on physical examination negative Spurling bilaterally. She had tenderness to palpation over the paraspinal muscles especially on the right of her cervical spine over the mid cervical region. Her muscle strength in the left upper extremity was 5/5 in the deltoids, biceps, triceps, wrist flexion, and extension. On the right her deltoid was 5/5, biceps 4+/5, triceps 5/5, wrist flexion and extension as well as interossei was 4+/5. Sensation was grossly intact and deep tendon reflexes were 1+ and symmetrical. The cervical MRI from February 24,2010 was reviewed and not so show a possible disk bulge at the level below which would make that the C6-7 level with no significant stenosis. The axials do not show any significant neuroforaminal stenosis at C6-7. Dr. felt it may just be an artifact and recommended a CT myelogram in order to get a better look at it.

November 3, 2010: Script for Orders by MD with the back Institute requesting a cervical Myelogram/CT, and a left upper extremity EMG/NCS. Diagnosis listed: 723.1, Cervicalgia.

December 27, 2010: EMG/NCS of the right upper extremity revealed: There is subtle, but not conclusive, electrodiagnostic evidence of a right C7 radiculopathy. There is no evidence of distal right upper extremity neuropathy. Recommendations were made for a CT myelogram of the cervical spine would be useful since the claimant has progressive sense of weakness and there are subtle electrodiagnostic changes consistent with a radicular source and no evidence of a distal upper extremity neuropathy. Interpreted by, MD.

January 13, 2011: The claimant was re-evaluated by MD who found on physical examination motor was 4/5 right grip, intrinsics and APB; other areas 5/5. Sensory was decreased to pinprick in a C6-7 distribution in the right upper extremity. There was tenderness in the right cervicothoracic region on palpation without masses or spasms. He refilled her prescription for Avinza 60 qd and Tramadol and instructed her to follow up with the Back Institute.

April 21, 2011: MD, an orthopedic surgeon, performed a utilization review on the claimant. Rational for Denial: Records do not reflect any acute changes in physical examination findings to warrant proceeding with a CT myelogram of the cervical spine. The claimant has had ongoing complaints of radicular symptoms throughout the course of treatment. Official Disability Guidelines only supports myelogram for planned surgical procedures. Records do not reflect surgery is planned or warranted in this claimant.

April 22, 2011: The claimant was re-evaluated by, MD who found on physical examination an absent right triceps reflex and a positive Spurling maneuver on the right with radiation down the arm. Dr. recommended a cervical myelogram CAT scan with MRI scan.

May 3, 2011: , MD, and orthopedic surgeon, performed a utilization review on the claimant. Rational for Denial: The provider proposed for a cervical myelogram with CAT scan for further evaluation of her current symptoms . In line with referenced guidelines, there are no evidence-based studies that support routine myelography. No clear indication in the latest treatment plan dated 4/22/11 that surgery is being contemplated. The results of the recent cervical MRI are not equivocal or inconclusive to justify the need for further imaging studies. There is no clear indication provided in the reports which shows that the claimant has failed prior conservative measures.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant has a history of injury to her neck at work back in when she fell off the back of a truck. She also sustained a right neck injury that required ACDF at C5-6 in xxxx.

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

The previous decisions are upheld. There is no indication in the medical records provided that the Cervical Myelogram/cat scan is for surgical planning. Based on the ODG Cervical Myelogram/cat scan is for surgical planning only; therefore, without mention of planned surgical intervention the previous decisions are upheld.

Per ODG:

Cervical Myelogram/cat scan:

Not recommended except for surgical planning. Myelography or CT-myelography may be useful for preoperative planning. (Bigos, 1999) (Colorado, 2001)

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)**