

ReviewTex
1818 Mountjoy Drive
San Antonio, TX 78232
Phone: 210-598-9381
Fax: 210-598-9382

Notice of Independent Review Decision

DATE OF REVIEW: 1/27/12

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Myelography, Cervical, Radiological Supervision and Interpretation
Dates of Service From 12/28/2011 to 12/29/2011

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

Board Certified Neurosurgeon

REVIEW OUTCOME

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

Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. 09/22/08 – Radiographs Thoracic Spine
2. 09/22/08 – CT Thoracic Spine
3. 11/25/08 – MRI Cervical Spine
4. 11/25/08 – MRI Thoracic Spine
5. 11/25/08 – MRI Lumbar Spine
6. 12/07/08 – Electrodiagnostic Studies
7. 01/12/09 – MRI Lumbar Spine
8. 08/01/10 – MRI Lumbar Spine
9. 10/28/10 – Clinical Note –
10. 01/24/11 – Clinical Note –
11. 01/27/11 – MRI Cervical Spine
12. 03/14/11 – Clinical Note –
13. 06/06/11 – Appeal Request
14. 06/07/11 – Utilization Review Determination
15. 09/01/11 – Clinical Note –
16. 12/01/11 – Clinical Note –
17. 12/29/11 – Peer Review Report
18. 12/29/11 – Utilization Review Determination

19. 01/09/12 – Peer Review Report

20. 01/09/12 – Utilization Review Determination

PATIENT CLINICAL HISTORY (SUMMARY):

The claimant is a male who sustained an injury on xx/xx/xx when a large metal bell struck his back.

Radiographs of the thoracic spine performed 09/22/08 revealed no obvious vertebral body fracture. There were right-sided rib fractures involving the ninth and tenth posterior ribs.

CT of the thoracic spine performed 09/22/08 revealed non-displaced fractures of the right eighth, ninth, and tenth transverse processes, and the right eighth, ninth, and tenth ribs posteriorly. There were bibasilar atelectatic changes present.

MRI of the cervical spine performed 11/25/08 revealed early disc degeneration at C4-5. There was evidence of small left posterior spur formation, as well as posterior central, left paracentral disc protrusion without extrusion and impression upon the thecal sac. There was no involvement of the exiting right or left nerve roots at C5. At C5-6, there was early disc degeneration, as well as a broad-based posterior central disc protrusion without extrusion and impression upon the thecal sac, as well as neural foramina abutting against both exiting right and left nerve roots of C6. There was a mild to moderate degrees of central spinal canal stenosis.

MRI of the thoracic spine performed 11/25/08 revealed disc dehydration and desiccation from T2 through T10. There was an old Schmorl's node noted. MRI of the lumbar spine performed 11/25/08 revealed diminished disc signal intensity at L5-S1. There was a small posterior central, right paracentral radial annular tear without associated disc protrusion or extrusion.

Electrodiagnostic studies performed 12/17/08 revealed NCS evidence of right S1 sensory neuropathy and right L5 and S1 radiculopathy, as well as EMG evidence of chronic right S1 and chronic left L5 radiculopathy. MRI of the lumbar spine performed 01/12/09 revealed a central annular tear and facet arthrosis at L5-S1. There was no significant canal stenosis or neural foraminal narrowing.

MRI of the lumbar spine performed 08/01/10 revealed annular tearing at L5-S1 in the midline posteriorly. The ligaments and facets were unremarkable. There was no canal or significant foraminal narrowing. There was mild disc desiccation at L5-S1.

The claimant saw on 10/28/10 with complaints of low back pain rating 10 out of 10. Physical exam revealed blunted reflexes of the patella and Achilles. The claimant was assessed with lumbar disc displacement with myelopathy, lumbar spinal stenosis, and lumbago. The claimant was recommended for MRI and electrodiagnostic studies.

The claimant saw on 01/24/11 with complaints of pain to the neck, low back, and leg. Physical exam revealed no tenderness to palpation of the neck. There was no tenderness to palpation of the lumbar spine. The claimant was assessed with lumbago, lumbar spinal stenosis, and lumbar disc displacement with myelopathy. The claimant was recommended for L5-S1 retroperitoneal anterior lumbar interbody fusion. MRI of the cervical spine performed 01/27/11 revealed straightening of the cervical spine as a result of muscle spasm. There was moderate narrowing

of the left C3-4 neural foramen secondary to left-sided posterolateral osteophyte. There were mild diffuse disc bulges from C4-5 to C6-7 with mild attenuation of the anterior subarachnoid spaces. There was associated moderate narrowing of the bilateral neural foramina at C4-5, C5-6, and C6-7. There was minimal central spinal canal stenosis at C4-5 to C6-7.

The claimant saw on 03/14/11 with complaints of neck pain with associated popping, major headaches, and dizziness. The claimant rated her pain at 10 out of 10. Physical exam revealed no tenderness to palpation of the cervical spine. There was full range of motion. The claimant was assessed with neck pain, cervical disc displacement with myelopathy, cervical spinal stenosis, lumbago, lumbar spinal stenosis, and lumbar disc displacement with myelopathy. The claimant was recommended for C4-6 anterior cervical discectomy and fusion.

The claimant saw on 09/01/11 with complaints of neck pain with associated headaches and dizziness. Physical exam revealed diminished sensation in the bilateral shoulders, triceps, biceps, and right forearm. There was tenderness to palpation at C5-6 and T9-10. Spurling's was positive. Straight leg raise was reported to be positive at 20 degrees bilaterally. There was weakness of the lower extremities. The deep tendon reflexes were diminished throughout. The claimant was assessed with neck pain, cervical disc displacement with myelopathy, cervical spinal stenosis, lumbago, lumbar spinal stenosis, and lumbar disc displacement with myelopathy. The claimant was recommended for C4-6 anterior cervical discectomy fusion.

The claimant saw on 12/01/11 with complaints of chronic neck pain. Physical exam revealed tenderness to palpation of the cervical spine. The claimant was assessed with major depressive disorder, lumbar intervertebral disc disorder with myelopathy, thoracic intervertebral disc disorder with myelopathy, traumatic amputation of the arm, neuralgia, closed from of T7-12, displacement of cervical intervertebral disc without myelopathy, derangement of anterior horn of lateral meniscus, cervicgia, contusion of hands, complete rupture of rotator cuff, lower leg contusion, backache, sprain of cruciate ligament of knee, hypothyroidism, goiter, and psychosexual dysfunction. The claimant was referred for further evaluation. The request for myelography, cervical, radiological supervision and interpretation was denied by utilization review on 12/29/11 as the history and documentation did not objectively support the request for a myelogram CT for the cervical spine. It was not clear what was being sought out, why the MRI that was performed was insufficient, or what additional benefit may be received by the claimant by doing a different study. The request for myelography, cervical, radiological supervision and interpretation was denied by utilization review on 01/09/12 as the submitted clinical records did not provide any data to establish progressive neurologic deficit. As the claimant had already undergone MRI of the cervical spine, there was no indication that any additional information would be provided for pre-operative planning.

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

The requested Myelography, Cervical, Radiological Supervision and Interpretation is not supported by the clinical documentation or consistent with current evidence based guideline recommendations.

The claimant has had two previous MRI studies of the cervical spine that revealed multi level diffuse disc bulging and foraminal narrowing. The claimant's physical exams since the January 2011 MRI have been consistent with no significant neurological changes noted in the upper extremities. Given the lack of any objective evidence of progressive neurological deficits and no

clear rationale from the attending physician on why a CT myelogram of the cervical spine is required, medical necessity for the request is not established.

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

REFERENCES:

Official Disability Guidelines, Online Version, Neck & Upper Back.

Myelography: Not recommended except for selected indications below, when MR imaging cannot be performed, or in addition to MRI. Myelography or CT-myelography may be useful for preoperative planning. (Bigos, 1999) (Colorado, 2001) Myelography and CT Myelography has largely been superseded by the development of high resolution CT and magnetic resonance imaging (MRI), but there remain the selected indications for these procedures, when MR imaging cannot be performed, or in addition to MRI. (Mukherji, 2009)

ODG Criteria for Myelography and CT Myelography:

1. Demonstration of the site of a cerebrospinal fluid leak (postlumbar puncture headache, postspinal surgery headache, rhinorrhea, or otorrhea).
2. Surgical planning, especially in regard to the nerve roots; a myelogram can show whether surgical treatment is promising in a given case and, if it is, can help in planning surgery.
3. Radiation therapy planning, for tumors involving the bony spine, meninges, nerve roots or spinal cord.
4. Diagnostic evaluation of spinal or basal cisternal disease, and infection involving the bony spine, intervertebral discs, meninges and surrounding soft tissues, or inflammation of the arachnoid membrane that covers the spinal cord.
5. Poor correlation of physical findings with MRI studies.
6. Use of MRI precluded because of:
 - a. Claustrophobia
 - b. Technical issues, e.g., patient size
 - c. Safety reasons, e.g., pacemaker
 - d. Surgical hardware