

MAXIMUS Federal Services, Inc.  
4000 IH 35 South, (8th Floor) 850Q  
Austin, TX 78704  
Tel: 512-800-3515 ♦ Fax: 1-877-380-6702

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**Notice of Independent Review Decision**

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Austin, TX 78704  
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**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** October 24, 2012

**IRO CASE #:**

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

CT Cervical Spine without & with contrast material, 72127  
Myelography 2/More Regions RS&I, 72270  
Injection Procedure Myelography/CT Spinal, 62284

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

M.D., Board Certified in Radiology.

**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)

The requested CT Cervical Spine without & with contrast material, 72127 is not medically necessary for evaluation of the patient's medical condition.

The requested Myelography 2/More Regions RS&I, 72270 is not medically necessary for evaluation of the patient's medical condition.

The requested Injection Procedure Myelography/CT Spinal, 62284 is not medically necessary for evaluation of the patient's medical condition.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Request for a Review by an Independent Review Organization dated 10/08/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 10/08/12.
3. Notice of Assignment of Independent Review Organization dated 10/09/12.
4. Denial documentation.
5. Workers Compensation Pre-Authorization Request Form dated 9/19/12.
6. Medical records from The Centre dated 6/14/12, 7/16/12, 8/16/12, and 9/18/12.
7. Medical records from Physical Therapy dated 5/27/12, 7/31/12, 8/15/12, 9/05/12, and 9/17/12.
8. Letter from dated 10/12/12.
9. Letter from MD dated 9/25/12.
10. Medical records from MD dated 6/14/12 through 10/06/12.
11. Texas Worker's Compensation Work Status Report dated 6/14/12, 7/19/12, and 9/18/12.
12. Urinary drug test dated 6/14/12.
13. Undated document entitled Review of Symptoms.
14. Questionnaire dated 6/14/12.
15. Worker's Compensation Information Sheet dated 6/04/12.
16. Undated narcotic contract.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who was injured on xx/xx/xx after she was hit in the head with a backpack. On 6/14/12, the patient reported neck pain. She described the symptoms as severe. Her prior treatment included nonsteroidal anti-inflammatory medication and physical therapy. The patient reported mostly right-sided cervicgia and suboccipital pain. There were no upper extremity symptoms. Physical examination noted that sensation to pinprick was intact, as was light touch. Her upper extremity strength was noted as 5/5 in all areas tested. In general, reflexes were symmetrical bilaterally. Per the medical records, examination of the cervical spine noted no tenderness to palpation. There were no paravertebral muscle spasms or masses. There was decreased flexion, extension, right-sided bending, and left-sided bending. There was normal

range of motion of the bilateral shoulders, elbows, and wrists. Upper extremity atrophy was not present. On 9/18/12, the patient reported continued neck pain. The medical records noted that prior cervical spine x-rays showed moderate C6-7 degenerative disc disease and mild C5-6 anterolisthesis. The documentation noted that the patient had approximately 11 sessions of physical therapy. A cervical CT/myelogram was recommended.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested diagnostic studies. Specifically, the URA's initial denial noted that the documentation does not provide any evidence of positive findings on neurologic examination to warrant the cervical CT/myelogram. On appeal, the URA noted that the patient does not present with objective findings consistent with neurologic deficit, such as decreased strength, sensation, or reflexes. Per the URA, absent evidence of progressive neurologic deficit, the medical necessity of the requested cervical CT/myelogram is not established.

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

The Official Disability Guidelines (ODG) note the criteria for a myelogram and CT myelogram to include demonstration of a site of cerebral spinal fluid leak, surgical planning, a diagnostic evaluation of spinal or basal cisternal disease, poor correlation of physical findings with MRI studies or the use of an MRI is precluded because of claustrophobia, technical issues, safety reasons, or surgical hardware. Myelogram and CT myelogram have largely been superseded by the development of high resolution CT scans. The patient is not noted to be a surgical candidate at this time. The ODG criteria note that for the evaluation of patients with chronic neck pain, plain radiographs should be the initial study performed. This patient was noted to have plain radiographs. However, they were not submitted for review. Patients with normal radiographs and neurological signs or symptoms should undergo further imaging studies. In this patient's case, there is a lack of documentation demonstrating significant changes in pathology or progressive neurologic deficits on examination. Without further documentation to note the patient's neurological findings, the medical necessity of the requested diagnostic studies cannot be established. All told, the requested cervical CT/myelogram is not medically indicated in this patient's case.

Therefore, I have determined the following:

the requested CT Cervical Spine without & with contrast material, 72127 is not medically necessary for evaluation of the patient's medical condition;

the requested Myelography 2/More Regions RS&I, 72270 is not medically necessary for evaluation of the patient's medical condition; and

the requested Injection Procedure Myelography/CT Spinal, 62284 is not medically necessary for evaluation of the patient's medical condition.

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**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 JUDGMENT, 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)**