



Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 10/27/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The item in dispute is the prospective medical necessity of a cervical myelogram with CT.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery.

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 reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a cervical myelogram with CT.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant was noted to have been injured in xx/xxxx. He was noted to have sustained neck and back pain. Treatment has included restricted activities and medications. Clinical notes reveal cervical dorsal lumbar paraspinal spasm. There was noted to be a normal range of motion at the cervical spine level. There is a left-sided posited Spurling sign at the cervical spine. The neurologic examination of motor power, sensation and reflexes was noted to be unremarkable. A cervical MRI scan from June 10, 2014 revealed herniations at C5-6, C6-7 and C7-T1 along with significant spinal stenosis at multiple cervical levels. Electrical studies from June 19, 2014 revealed evidence of mild carpal tunnel syndrome. The most recent clinical records including from August 19, 2014 revealed it decrease of strength of gripping along with 5-/5 weakness of the

deltoid muscle and at most 4+/5 strength at the biceps and triceps bilaterally. There was equivocal weakness of wrist dorsiflexion noted. The triceps reflexes were noted at 2+ while the biceps were noted at trace to absent. There is a consideration for surgical intervention with a pre-surgical CT myelogram in order to further assess for significant cervical stenosis. The provider also indicated that the MRI images were only of fair quality.

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

The abnormalities on the MRI scan evidence stenosis at multiple levels of the cervical spine (C 5-6 and C 6-7). These clinical abnormalities do correlate with the MRI findings. There is also no corroborative documentation that the MRI images are of inadequate quality to allow for a surgical determination (or lack thereof). Therefore, as noted in the following ODG reference; the consideration for the CT-Myelogram is not medically necessary as per applicable clinical guidelines

ODG Neck Chapter 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

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)**