AccuReview

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Notice of Independent Review Decision

[Date notice sent to all parties]: October 24, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical CT/Myelogram

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

This physician is Board Certified in Orthopaedic Surgery with over 15 years of experience.

REVIEW OUTCOME:

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

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male whom was reportedly involved in a motor vehicle accident. He was wearing a seatbelt and was able to get out of the vehicle by his own self and transported to the hospital for evaluation. Reportedly he had soft-tissue injury with abrasions involving the left side and bruised hip, however, seemed to have some visual changes since that happened. Evaluation at the emergency department revealed low potassium and high sugar, which he was treated. Claimant had mild headache, decreased blurred vision with no history of diplopia, released. He cannot recall hitting his head.

Xx/xx/xx: Office Visit. Assessment: MVA E819.9, resulting in possible head injury. Claimant had some visual field cut and subconjunctival hematoma. Refer to eye doctor for evaluation. Because of injury, CT head will be ordered. Multiple abrasions 919.0 – with bruising. PE: Pupils have subconjunctival hematoma left aspect of conjunctiva. Pupils equal. There is questionable decreased visual field

cut on left side but not reproducible. No nystagmus noted. Left arm had superficial abrasion healing well; left hip had a bruise on the hip and superficial abrasion on the back.

03-28-14: Office Visit. CC: eye irritation. Assessment: Visual field defect NOS 368.40, Photophobia of left eye 368.13. Plan: symptoms are improving. Confrontational fields are not consistent with Humphrey visual fields. No sign of intraocular inflammation, retinal damage, or orbital fracture. Retur?traumatic optic neuropathy (but there was no RAPD). Return to clinic on Tuesday for repeat Humprey visual field, if no improvement, recommend MRI brain and orbit with and without contrast.

03-31-14: Office Visit. Assessment/Plan: head injury 959.01, resulting in visual changes; improving. Since CAT scan is normal reassure, will go ahead take Tramadol for pain; no driving yet. Cervical strain 847.0 with left neuropathy, go ahead avoid lifting and straining, no driving, start trazanidine and add Tramadol for pain, start on Medrol Dosepak for neuropathic pain of left arm, and recheck in 1 wk. PE: tenderness over anterior aspect of the head. Left eye: subconjunctival inflammation and improving. Neck: tightness neck muscle, trapezius muscle tenderness with increased rotation flexion and extension. Musculoskeletal: pain down left arm, left shoulder in good ROM.

03-31-14: AP and Lateral C-Spine. Impression: Congenital block vertebrae C2-3. Straightening of the C-spine which may reflect muscle spasm versus positioning. No other definite abnormalities identified.

04-07-14: Left Shoulder AP view. Impression: negative left shoulder.

04-07-14: Office Visit. Assessment/Plan: MVA E819.9 with head injury/visual field changes; improving. Cervical strain 847.0 with left neuropathy. This has become more of a problem. Shoulder x-ray will be done. Claimant's pain initially more in the left forearm, he will go ahead with MRI of the neck. Continue current medication, no driving, limit activity. Recheck in 9 days. PE: Neck: tightness of neck muscle, decreased rotation because of discomfort, flexion and extension results in mild pain. Musculoskeletal: left shoulder tenderness on movement of the shoulder with pain down left arm.

04-14-14: MR C-Spine WO. Impression: mild cervical spondylosis. Study is slightly limited secondary to patient motion. No canal stenosis. Mild to moderate left neural foraminal narrowing C4-5, associated with primary spondylolisthesis.

04-15-14: Office Visit. Assessment/Plan: MVA E819.9, resolved with head injury. Visual changes 368.9, resolved. Neck pain 723.1 with left neuropathy. Left forearm pain 729.6, resolved. Claimant still has numbness, consider therapy, and continue limited duty with no driving. Recheck in 7-10 days. PE: neck: some tightness neck muscle with some discomfort on rotation and flexion. Tightness left trapezius muscle. Decreased sensation over left hand subjectively.

04-30-14: Office Visit. Assessment/Plan: MVE E819.9 resulting in head injury; resolved. Left arm pain 729.6; resolved except for persisting neuropathy. Neck pain 723.1, not resolved. Cervical spondylosis 721.0. Suggest therapy. Claimant will likely have some discomfort after that because of spondylosis. Naproxen 375mg bid and muscle relaxant as well as pain pill prn, stretching exercise, may work without driving tractor trailer, recheck again in 13 days. PE: neck: decreased rotation to the right, muscle tightness both sides of trapezium, flexion and extension intact. Musculoskeletal: left arm good ROM, there are some subjective sensory changes in the forearm.

05-13-14: Neurophysiological Consultation and Report of Electrodiagnostic. Physical examination revealed ROM of the cervical spine in flexion, extension, and rotation are within normal limits. Neuro examination: neurological examination revealed strength to be 5/5 proximally and distally in the upper extremities. Sensation is subjectively decreased throughout the lateral aspect of the left arm, digits 1-5 and the medial aspect of the left forearm. Otherwise, sensation is within normal limits. Deep tendon reflexes are +1 at the right biceps, absent at the left biceps, +1 at the bilateral triceps, +3 at the bilateral patellas and +3 at the bilateral ankles. There is a reproducible Hoffmann's in the left upper extremity, but not the right. There is 2-3 beat clonus noted on the right, but not the left. EMG/Nerve Conduction Testing: Impression: 1. EMG evidence of bilateral C5-6 cervical radiculopathy/injury. 2. NCV evidence of severe left median nerve entrapment across the carpal tunnel. 3. No NCV evidence of generalized peripheral neuropathy, plexopathy or other entrapments. Discussion and Complex Medical Decision Making: The claimant's electrodiagnostic studies demonstrate active denervation in the left C5-6 distribution as tested, suggesting an element of cervical radiculopathy or cervical injury in and around C5-6. There was also severe motor sensory slowing of the left median nerve across the carpal tunnel, but no NCV evidence of generalized peripheral neuropathy or other peripheral nerve entrapments.

05-15-14: Office Visit. Assessment/Plan: MVA E819.9 resulting in head injury with posttraumatic headache. Cervical disc disease 722.91 with neuropathy. MRI results discussed, no bulging disc, with retinopathy, refer to second opinion. Finish therapy, continue Tramadol for pain, Zanaflex 3 times a day, Gabapentin 300mg bid, recheck in couple of weeks, continue limited work, no driving. PE: EMG testing showed carpal tunnel syndrome left and bilateral C5-6 cervical retinopathy. Neck: some tightness and tenderness over the left trapezius muscle. Rotation minimally decreased, flexion and extension unremarkable. Musculoskeletal: left arm has decreased sensation over the forearm and hand with mild subtile decreased handgrip.

05-20-14: Plan of Care. Assessment/diagnosis: claimant will benefit from continued skilled PT to increased ROM, decrease pain, improve strength, and return claimant to previous level of functioning. Claimant problems: limitation with carrying, moving, and handling objects. Plan: 2-3 x wk, duration 1 month. Procedures: therapeutic exercises, therapeutic activity, neuromuscular rehabilitation, manual therapy, massage, patient education. Modalities: to

improve (pain relief, decrease inflammation, improve tissue healing), electrical stimulation (inferential), ultrasound/phonophoresis, infrared light, cryotherapy, hot packs.

07-14-14: Office Visit. PE: musculoskeletal: shoulder has good ROM with minimal discomfort on internal rotation. Tinel sign positive on the left, sensation decreased globally in the forearm and there is pain on anterior aspect of the left upper arm subjectively. Assessment/Plan: MVA E819.9 resulting in neck and head injury; resolved. Neck injury 959.09, with left neuropathy; persisting. Increase Gabapentin to 3x day, Tramadol for pain and renew naproxen, scheduled to see specialist this week, finish therapy, and recheck in 2 weeks, limited work.

08-26-14: Office Visit. Claimant wants to be released back to work. He claimed to have some mild headache in the last few weeks, may be tension headache. PE: Neck: mild tightness to the left trapezius muscle. Musculoskeletal: left arm shows no appreciable weakness, there is some sporadic numbness and sensation on pinprick left arm, does not follow dermatome. Assessment/Plan: Head injury 959.01, resolving with headache. This could be stress versus posttraumatic headache, injury to far away from having headache. Neck pain 723.1 with neuropathy, related to cervical spondylolisthesis and cervical spondylosis. Claimant wants to be released and does not want to further imaging study. HE is anxious to go back to work, will release to full-duty. No risk at this point; agreed with plan. Take neurontin on prn basis and naproxen as needed, Tylenol for headache.

09-04-14: UR. Reason for denial: The script for orders dated 08/12/2014 indicated a cervical spine myelogram had been ordered. The ODG guidelines state that myelogram is not recommended except for selected indications, when MR imaging cannot be preformed, or in addition to MRI. Myelography or CT myelography may be useful for preoperative planning. The criteria for myelogram and CT myelogram is demonstration of the site of a cerebrospinal fluid leak; surgical planning; radiation therapy planning; diagnostic evaluation of spinal or basal cisternal disease; poor circulation of physical findings with MRI is precluded because of claustrophobia, technical issues, safety reasons, and surgical hardware. An official MRI of the cervical spine dated 04/14/2014, revealed mild cervical spondylosis; study is slightly limited secondary to claimant motion; no canal stenosis, mild to moderate neural foraminal narrowing C4-5, associated with primary spondylolisthesis. The records submitted for review failed to include documentation of a rationale to support a CT myelogram. Given the above, the request for cervical CT/myelogram is non-certified.

09-24-14: Office Visit. Claimant complained of headache and popping seems worse, neck pain continues with increased difficulty. He continues to have numbness in hands. is recommending further MRI. MRI done in April showed spondylosis as well as spondylolisthesis with foraminal narrowing. PE: Neck: sensitive in the neck, movements results in severe pain, mild muscle spasm. Assessment/Plan: Neck pain 723.1 with left neuropathy C5-6. Posttraumatic

headache 339.20. Claimant has trouble sleeping, use Amitriptyline 25mg at bedtime, refer to designated doctor for assessment, go ahead with Tramadol for pain, recheck in the middle of October, no driving.

09-30-14: UR. Reason for denial: The documentation provided did not indicate that there was a poor correlation of physical findings with previous MRI study or that the use of an MRI was contraindicated based on the claimant's condition of either claustrophobia, technical issues, safety reasons, or surgical hardware. The documentation provided did not indicate that surgery was discussed or recommended to support the request for CT myelography. The documentation provided failed to indicate the medical necessity for the requested CT myelogram. The documentation provided failed to identify any exceptional factors or any significant objective functional deficits remaining after conservative care to warrant further evaluation. Based on the above cited, the appeal cervical CT/myelogram is non-certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse determinations are upheld and agreed upon. The claimant does not require a CT myelogram of the cervical spine. The CT myelogram is a useful diagnostic study for claimants who are not able to complete a MRI study because of claustrophobia, surgical hardware, or other medical contraindications. It is also useful for pre-operative evaluation of the cervical spine. The claimant has completed a MRI of the cervical spine in April 2014. The MRI demonstrated mild cervical spondylosis without evidence of canal stenosis. Mild to moderate neuroforaminal narrowing was noted at C4-5, with associated spondylolisthesis. A minimal posterior osteophyte at C5-6 was also identified. A subsequent EMG/NC study confirmed radiculopathy at C5-6. Based on the records and documentation reviewed, the CT myelogram would not add additional information to the results of the MRI and EMG/NC study. The claimant is also not a surgical candidate based on the records reviewed. Therefore, the request for Cervical CT/Myelogram is not medically necessary and denied.

Per ODG:

Myelography	**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

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)**