# True Decisions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**
Aug/01/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**
CT Myelogram (Cervical) Spine and Flex/Ext views and AP/Lat

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

**REVIEW OUTCOME:**

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

[ X ] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

**Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.**

**PATIENT CLINICAL HISTORY [SUMMARY]:**
The claimant is a female who reportedly was injured on xx/xx/xx. She states that she felt onset of pain in her neck the next morning. The claimant describes right sided neck pain with radiation into the right upper extremity. MRI of the cervical spine dated 11/09/12 revealed tiny central disc protrusion at C4-5 and C6-7 without impingement on spinal cord or nerve root. The claimant was seen in neurosurgical consultation on 01/06/14 with complaints of right sided neck pain with radiation into the right upper extremity into the shoulder and down to the elbow with associated numbness and tingling. She was noted to be status post physical therapy with no significant improvement in symptomatology. Past surgical history was significant for right carpal tunnel release and C-section. The claimant was noted to be pending right shoulder surgery. Current medications were listed as hydrocodone and gabapentin. On examination cervical range of motion was decreased in all planes, particularly lateral rotation secondary to pain. Motor examination was limited, but note was made of breakaway strength of the deltoid muscle on the right. Left upper extremity was 5/5 throughout. Deep tendon reflexes were +2 and symmetric throughout. The claimant had no gait abnormalities. Straight leg raise was not tested. Spurling's sign was positive on the right. There was slight hypoesthesia over the right C5, C6 and C7 distributions. The claimant was seen in follow-up on 05/15/14 with no significant improvement. Examination on this date revealed cervical range of motion was restricted in lateral rotation secondary to pain. Motor exam revealed 4/5 strength of the deltoid, biceps brachii, wrist extensors and triceps on the right, otherwise 5/5 throughout. Deep tendon reflexes were +2 and symmetric throughout. Spurling's sign was positive on the right. Sensory exam revealed a hypoesthetic region over the C5, C6 and C7 distributions on the right to pin prick and light touch, otherwise intact.

Coordination was intact. Due to interval change in neurologic status, cervical MRI and cervical spine series including flexion and extension views were recommended. The claimant was next seen on 06/02/14 without improvement. Physical examination was essentially unchanged from previous visit, except sensory changes were noted only over the C5 and C6 distributions on the right; motor strength was 4/5 strength of the deltoid muscle on the right, with 4+/5 strength of the biceps brachii and wrist extensor muscles on the right. CT myelogram was recommended. Per utilization review dated 06/18/14, the request for cervical spine CT myelogram and x-rays with flexion/extension and AP/lateral views was non-certified, noting that previous MRI has already adequately ruled out treatable and surgical cervical spine pathology; physical examination is not concordant with negative MRI results and physical examination findings have not changed. A reconsideration request was non-certified on 06/27/14 after discussion with the requesting provider, noting that there was insufficient evidence that there has been a change in claimant's complaints or that there has been neurological deterioration since undergoing MRI of the cervical spine, and in fact exam improved on 06/02/14 compared to prior exam on 05/15/14.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:**
The claimant sustained an injury on xx/xx/xx and developed right sided neck pain the next morning. MRI of the cervical spine was performed on 11/09/12, and showed only tiny central disc protrusion at C4-5 and C6-7 without impingement on spinal cord or nerve root. The claimant was seen in neurosurgical consultation and the claimant was noted to have some motor and sensory changes; however, it appears that the motor deficits may have been secondary to pain rather than a neurologic deficit. Her examination actually improved between 05/15/14 and 06/02/14. The claimant reportedly had failed to improve with physical therapy, but there was no comprehensive history of conservative treatment to date with physical therapy progress notes, procedure notes of injections, or other evidence of conservative measures completed. Based on the clinical information provided, it is this reviewer's opinion that medical necessity is not established for the requested cervical CT myelogram and radiographs with flexion and extension views and AP/lateral views. There is no evidence that MRI is unavailable, contraindicated or inconclusive. There is no evidence of a surgical lesion that would support the need for CT myelogram for surgical planning. The claimant's physical examination does not correlate with imaging findings, and there is no evidence of progressive neurologic deficit. As such, the request for cervical CT myelogram and flexion/extension views and AP/lateral views is not recommended as medically necessary

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**
**[ ] ACOEM-AMERICA 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**
**[ X ] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
**[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
**[ ] MILLIMAN CARE GUIDELINES**
**[ X ] 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)**