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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Feb/10/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: O/P myelogram w/post cervical CT

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Neurological 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is this reviewer's opinion that the request for O/P myelogram w/post cervical CT is not indicated as medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical note dated 05/16/12
Clinical note dated 07/18/12
Clinical note dated 09/28/12
Clinical note dated 10/22/12
Clinical note dated 11/19/12
Clinical note dated 12/17/12
Clinical note dated 01/14/13
Clinical note dated 02/11/13
Clinical note dated 03/11/13
Clinical note dated 04/08/13
Clinical note dated 05/06/13
Clinical note dated 05/29/13
Clinical note dated 06/03/13
Clinical note dated 07/01/13
Clinical note dated 07/17/13
Clinical note dated 07/29/13
Clinical note dated 09/18/13
Clinical note dated 09/27/13
Clinical note dated 10/21/13
Clinical note dated 10/23/13
Clinical note dated 11/04/13
Clinical note dated 11/13/13
Clinical note dated 11/19/13
Clinical note dated 12/02/13
Clinical note dated 12/04/13

Clinical note dated 12/18/13
MRI of the left shoulder dated 05/29/12
Electrodiagnostic studies dated 06/05/12
MRI of the cervical spine dated 06/13/12
Electrodiagnostic studies dated 06/19/13
Operative report dated 08/27/13
Adverse determinations dated 11/22/13 & 12/23/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury regarding his head, neck, and shoulder. The clinical note dated 05/16/12 indicates the patient complaining of back, left shoulder, and arm pain. The note mentions the patient stating the initial injury occurred on xx/xx/xx. The patient reported constant mid back and left shoulder pain. Numbness was noted in the left forearm and hand as well as tingling in the left upper arm. All activities were noted to exacerbate the patient's symptoms. Weakness was also noted in the left upper extremity. The MRI of the cervical spine dated 06/13/12 revealed a small central disc protrusion with a radial annular tear at C5-6. Mild facet osteoarthritis was noted on the left at C4-5 and C5-6. The clinical note dated 12/17/12 indicates the patient continuing with complaints of neck and head pain. The patient was noted to have continued complaints of persistent headaches as well as visual disturbance and a loss of memory. Radiating pain was noted from the neck into the left upper extremity all the way to the fingers. The clinical note dated 06/03/13 indicates the patient showing tenderness upon palpation over the paracervical region as well as the left trapezial region. The electrodiagnostic studies completed on 06/19/13 revealed essentially normal findings. No evidence of a radiculopathy, neuropathy, or plexopathy was noted. The clinical note dated 07/01/13 indicates the patient continuing with memory loss. However, the patient stated that it was improving. Muscle spasms were noted in the left arm. Pain continued at the trapezius region. The clinical note dated 07/29/13 indicates the patient showing decreased range of motion throughout the cervical region. No strength deficits or sensation issues were noted. The operative report dated 08/27/13 indicates the patient undergoing a C5-6 epidural steroid injection. The clinical note dated 09/18/13 indicates the patient continuing with persistent pain at the scapular region. The patient was noted to have tremors in the left upper extremity. Radiation of pain was noted from the cervical region primarily to the left hand. Weakness was noted at the right biceps that was rated as 5-/5. The patient rated the pain as 7/10 at that time. The clinical note dated 12/04/13 indicates the patient continuing with an aching, burning, and throbbing pain in the neck that was rated as 10/10. Numbness and tingling were also noted in the face, left arm, and hand. Weakness was also noted in the left upper extremity. The clinical note dated 12/18/13 indicates the patient continuing with ongoing symptomology with no significant changes. The patient was recommended for a CT myelogram of the cervical region.

The utilization review dated 11/22/13 resulted in a denial for a CT myelogram of the cervical region as the current examination findings do not reflect clear neurologic deficits that would warrant validation with the proposed study.

The utilization review dated 12/23/13 resulted in a denial for a CT myelogram as objective findings were limited supporting neurologic changes at that time.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient having complaints primarily in the cervical region with radiating pain to the upper extremities along with strength deficits. A CT myelogram would be indicated in the cervical region provided the patient meets specific criteria to include a noted cerebral spinal fluid leak; the need for surgical planning; radiation therapy planning; evaluation of spinal or basilar cistern disease and infections involving the bony spine, intervertebral discs, meninges, or surrounding soft tissues; poor correlation of physical findings with MRI studies or the use of an MRI is precluded. No information was submitted regarding the patient's significant clinical findings indicating a cerebral spinal fluid leak, surgical planning, radiation planning, or cisternal disease. The patient is noted to have previously undergone an MRI. Additionally, no information was submitted regarding the patient's physical findings not correlating properly

with the most recent MRI studies. As such, it is this reviewer's opinion that the request for O/P myelogram w/post cervical CT is not indicated 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

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)