

# INDEPENDENT REVIEWERS OF TEXAS, INC.

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## Notice of Independent Review Decision

### **[Date notice sent to all parties]:**

**03/04/2014**

### **IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** cervical CT myelogram with x-rays

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

Board Certified Orthopedic Surgeon

### **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.

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

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

The patient is a male who reported an injury to his cervical region. The x-rays of the cervical spine dated revealed facet arthropathy at C2 through C5. The MRI of the cervical spine dated 12/14/11 revealed multi-level disc disease with no central canal stenosis. Uncovertebral joint and facet hypertrophy were noted. Mild to moderate foraminal stenosis was noted bilaterally at C5-6. Foraminal narrowing was noted at C3-4 and C4-5. The clinical note dated 09/05/12 indicates the patient describing the initial injury as pulling resulting in the onset of neck pain. Radiation of pain was noted into the right shoulder and the lateral region of the upper extremity. The patient rated the pain as 9/10. Upon exam, 4/5 strength was noted at the biceps and wrist extensors on the right. Reflex deficits were noted at the right biceps. The patient was recommended to initiate physical therapy at that time. The therapy note

dated 01/06/12 indicates the patient continuing with 10/10 neck pain. Grip strength deficits were noted on the right. Tenderness was noted upon palpation at C5 through T2. Suboccipital tenderness was noted upon palpation. The x-rays of the cervical spine dated 02/23/12 revealed no acute fracture or subluxations throughout the cervical spine. Disc disease was noted at C5-6 and C6-7. The clinical note dated 03/20/13 indicates the patient having complaints of numbness in a non-dermatomal distribution throughout the right upper extremity. The patient rated his pain at that time as 7/10. The clinical note dated 05/10/13 indicates the patient continuing with radiating pain from the neck into the right shoulder and right upper extremity. The patient also had complaints of associated headaches. The patient described the pain as an aching throb at the base of the neck just right of the midline. The note does mention the patient having undergone a previous C5-6 anterior fusion. The clinical note dated 08/05/13 indicates the patient having moderate pain at the C5, C6, and C7 areas. No radiculopathy was noted. No motor or sensory deficits were identified. X-rays of the cervical spine dated 08/07/13 revealed the previous C5-6 fusion. A 1mm retrolisthesis of C5 was noted on C6 slightly increasing to 2mm on extension. A grade 1 anterolisthesis of C4 was noted on C5. This was noted to be increasing to 2.5-3mm on flexion. A 1.5-2mm grade 1 anterolisthesis of C3 was noted on C4 with a slight increase on flexion. A moderate disc space narrowing was noted at C6-7. The clinical note dated 08/16/13 indicates the patient having no complaints of arm pain, numbness, or tingling. The patient did describe muscle spasms with extension on the left side of the neck. The x-rays of the cervical spine dated 11/21/13 revealed 2mm of anterolisthesis of C3 on C4. A 1mm anterolisthesis was noted at C4 on C5. The clinical note dated 11/22/13 indicates the patient complaining of 8/10 pain throughout the cervical region. Radiating pain was noted into the right shoulder and upper extremity. Strength deficits were noted at the triceps brachii on the right.

The utilization review dated 12/24/13 resulted in a denial for a CT myelogram with x-rays as no information was submitted confirming a poor correlation of physical findings with the previous MRI studies as no MRI had been submitted at that time. Additionally, no evidence of the patient being a surgical candidate at that time was noted. No documentation was submitted regarding the patient's symptoms having progressed or significantly changed thus establishing the medical necessity for additional radiography.

The utilization review dated 01/15/14 indicates the patient having no indication for being a surgical candidate. No information was submitted regarding the patient's poor correlation of physical findings with the previous MRI studies.

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

The documentation indicates the patient having ongoing complaints of neck pain with radiation of pain to the right upper extremity. A CT myelogram of the cervical region would be indicated provided the patient meets specific criteria to include poor

correlation of the patient's clinical presentation with the available MRI findings. The clinical notes indicate the patient having strength deficits noted at the triceps on the right as well as hypoesthetic findings noted in the C7 distribution. The MRI of the cervical region revealed mild to moderate foraminal stenosis noted bilaterally at C5-6. Given the clinical presentation and taking into account the MRI findings, it does not appear that a poor correlation exists between the physical findings and the imaging studies. Additionally, the request for a repeat x-ray would be indicated provided the patient meets specific criteria to include significant changes or progression in the patient's symptomology noted by clinical exam. No information was submitted confirming the patient's significant changes or progressive findings. Therefore, the additional request for an x-ray has not been established. As such, it is the opinion of this reviewer that the request for a CT myelogram of the cervical region along with x-rays is not recommended as medically necessary.

## **IRO REVIEWER REPORT TEMPLATE -WC**

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### **A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

Myelography

Not recommended except for selected indications below, when MR imaging cannot be performed, or in addition to MRI. Myelography or CT-myelography may be useful for preoperative planning. (Bigos, 1999) (Colorado, 2001) Myelography and CT Myelography has largely been superseded by the development of high resolution CT and magnetic resonance imaging (MRI), but there remain the selected indications for these procedures, when MR imaging cannot be performed, or in addition to MRI. (Mukherji, 2009)

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

### Radiography (x-rays)

Not recommended except for indications below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging. Patients who do not fall into this category should have a three-view cervical radiographic series followed by computed tomography (CT). In determining whether or not the patient has ligamentous instability, magnetic resonance imaging (MRI) is the procedure of choice, but MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. (Anderson, 2000) (ACR, 2002) See also ACR Appropriateness Criteria™. Initial studies may be warranted only when potentially serious underlying conditions are suspected like fracture or neurologic deficit, cancer, infection or tumor. (Bigos, 1999) (Colorado, 2001) For the evaluation of the patient with chronic neck pain, plain radiographs (3-view: anteroposterior, lateral, open mouth) should be the initial study performed. Patients with normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging. If there is a contraindication to the magnetic resonance examination such as a cardiac pacemaker or severe claustrophobia, computed tomography myelography, preferably using spiral technology and multiplanar reconstruction is recommended. (Daffner, 2000) (Bono, 2007) There is little evidence that diagnostic procedures for neck pain without severe trauma or radicular symptoms have validity and utility. (Haldeman, 2008)

Indications for imaging -- X-rays (AP, lateral, etc.):

- Cervical spine trauma, unconscious
- Cervical spine trauma, impaired sensorium (including alcohol and/or drugs)
- Cervical spine trauma, multiple trauma and/or impaired sensorium
- Cervical spine trauma (a serious bodily injury), neck pain, no neurological deficit
- Cervical spine trauma, alert, cervical tenderness, paresthesias in hands or feet
- Cervical spine trauma, alert, cervical tenderness
- Chronic neck pain (= after 3 months conservative treatment), patient younger than 40, no history of trauma, first study
- Chronic neck pain, patient younger than 40, history of remote trauma, first study
- Chronic neck pain, patient older than 40, no history of trauma, first study
- Chronic neck pain, patient older than 40, history of remote trauma, first study
- Chronic neck pain, patients of any age, history of previous malignancy, first study
- Chronic neck pain, patients of any age, history of previous remote neck surgery, first study
- Post-surgery: evaluate status of fusion