

Vanguard MedReview, Inc.

4604 Timken Trail
Fort Worth, TX 76137

P 817-751-1632

F 817-632-2619

Notice of Independent Review Decision

January 21, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical Myelogram with CT 72240, 72125

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

This reviewer is a Board Certified Orthopedic Surgeon with over 42 years of experience.

REVIEW OUTCOME:

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

Overturned (Disagree)

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 who was involved in a motor vehicle accident on xx/xx/xx when he was driving and had a blowout tire and rolled over.

03/21/2014: Office Visit. **HPI:** white male brought in by mother for examination. Patient reportedly was involved in motor vehicle accident. He was out of town when patient was driving and had a blowout. The truck rolled and patient was injured. He had a seatbelt on, and was able to get out of the vehicle by his own self and transported to the hospital for evaluation. He reportedly had soft tissue injury with abrasion involving the left side and bruised hip, however, seems to have some visual changes since that happened. Evaluation in the emergency room was unremarkable except patient has low potassium and high sugar which patient is being treated for that. He has history of hydrochlorothiazide and low potassium in the past. Patient has some mild headache. There is decreased blurry vision per patient. No history of diplopia. This was noted after patient left the emergency room, per patient. He cannot remember hitting his head. **Physical**

Exam: Level of distress is mentally clear. Nourishment type is obese. Overall appearance is stuttering/chronic. Right: Fundus is benign Left: Fundus is benign. Pupils have subconjunctival hematoma left aspect of conjunctiva, pupils equal. There is questionable decreased visual field cut on left side but not reproducible. No hystagmus noted. Left arm has superficial abrasion healing well. Left hip has a bruise on the hip and superficial abrasion on the back. **Instructions:** Decrease caloric intake & maintain a healthy balanced diet. Exercise for at least 30 minutes daily.

03/31/2014: CSpine Exam. **Impression:** Congenital block vertebra C2-3. Straightening of the C-Spine which may reflect muscle spasm versus positioning. No other definite abnormalities identified.

03/31/2014: Office Visit. **HPI:** Patient has experienced some neck pain, headaches and numbness going down the left arm. Patient got hit on the right shoulder. He had x-ray of the arm only during the ER visit. He has no weakness just tingling and numbness down the left arm. **Physical Exam:** Pain down the left arm. Handgrip is unremarkable. Reflexes are normal. No subjective sensory changes. Left shoulder has good ROM. Motor and reflexes are grossly intact. **Medications:** Tramadol 50 mg tablet-Take 1 tablet by oral route every 6 hours as needed, Tizanidine 4mg tablet-Take 1 tablet by oral route every 12 hours as needed not to exceed 3 doses in 24 hours, Medrol (pak) 4mg tablets in a dose pack-take 1 by oral route as directed, Hydrochlorothiazide 25mg tablet-Take 1 tablet by oral route every day, propranolol 40mg tablet-Take 1 tablet by oral route 2 times every day. **Instructions:** Decrease caloric intake & maintain a healthy balanced diet exercise for at least 30 minutes daily.

04/07/2014: Left Shoulder Exam. **Impression:** AP film with the patient in internal and external rotation confirms normal anatomic alignment. No acute bony injury or radiopaque foreign body. AC joint is normal. Negative left shoulder

04/14/2014: MRI Cervical 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-C5, associated with primary spondylolisthesis.

04/15/2014: Office Visit. **HPI:** Patient sustained head injury with some visual changes and loss of visual field being checked. Head injury resolved but still has occasional headache. Overall improving. Vision is back to normal. Patient noticed some neck discomfort a few days after the accident and experienced some left arm discomfort and numbness over the left hand. This came after initial accident. Because of that, underwent MRI of the neck. Patient's condition has not changed. He is still taking muscle relaxant and tramadol and is restricted from driving. Shoulder is essentially stable and left forearm is unremarkable now. **Physical Exam:** Some tightness neck muscle with some discomfort on rotation and flexion. Tightness left trapezius muscle. Reflexes and motor function are intact. Decreased sensation over left hand subjectively. Radial pulses intact.

05/13/2014: Examination. **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 entrapment.

06/02/2014: Office Visit. **HPI:** Neck and arm moving better with therapy. He has done 9 treatments with 11 remaining. MRI shows disk protrusion. There is abnormal EMG with neuropathy as well as evidence of carpal tunnel. He complains of some weakness left hand and numbness and tingling up the left forearm. **Physical Exam:** Good Range of movement today. Mild tenderness left trapezius muscle. Left shoulder has good ROM. Right shoulder normal. Left arm handgrip slightly decreased compared to right. Positive Tinel sign. No loss of reflexes. **Plan:** Continue Physical Therapy and pursue second opinion with Back Institute. Patient will continue gabapentin twice a day, Zanaflex twice a day and tramadol as needed. DWC-73 done. Continue without driving. Dietary management education, guidance and counseling. Encouraged to exercise.

06/30/2014: Office Visit. **HPI:** Pt continues to suffer from some neck discomfort but overall improving. He is unable to work because he drives a truck. He is complaining of tingling down the left arm. The whole hand is affected with numbness and not much pain now. He is still receiving some physical therapy. Subjectively about 80% better. **Physical Exam:** No acute distress. Nourishment-overweight. There is minimal discomfort over the left trapezius muscle. Rotation, flexion and extension are markedly improved. Left shoulder is unremarkable. There is no motor weakness. Upper extremities numbness down the left arm. Handgrip is unremarkable today. **Assessment/Plan:** Patient has C5-6 neuropathy pending second opinion and patient improving. Might consider release to work after physical therapy. Recheck in 2 weeks. May work, no driving. Continue current meds. Tylenol for pain. Dietary management education, guidance and counseling as well as encouragement to exercise.

07/29/2014: Office Visit. **HPI:** MRI shows cervical spondylosis as well as foramen narrowing. Supposed to see couple weeks ago reportedly appointment was changed to August 12 for second opinion on neuropathy left arm. Since last visit, patient's numbness turned to arm pain affecting the forearm only. EMG showed radiculopathy. Patient claims to have increased Neurontin to 300mg 3 times a day. Patient complains of some weakness down the left hand at times. **Physical Exam:** Patient had objective pain down lateral aspect of the forearm. Handgrip slightly decreased on left compared to right. **Assessment/Plan:** Neck pain, with left neuropathy with cervical spondylosis. BMI 38.0-38.9, adult. Wait for specialist report.

08/12/2014: Office Visit. **HPI:** This patient is referred Ip for neck and back pain that radiates down left side. He states at times he does feel some numbness. He wakes up at night because of the pain, especially if he turns to the side. Laying for long periods also causes pain. **Physical Exam:** HEENT: Head is norm cephalic and atraumatic. Extra ocular muscles are intact. Pupils are round, equal and reactive. Oropharynx is clear. There is no JVD, thyromegaly, or cervical

Lymphadenopathy. **NECK:** Normal alignment, atraumatic, no masses or lymphadenopathy. **EXTREMITIES:** Good ROM to all joints in upper and lower extremities. **NEUROLOGICAL EXAM:** Cranial nerves 2-12 are grossly intact. Upper and lower extremity deep tendon reflexes are equal and symmetric and a grade of 2 out of 4. No long tract signs are seen. Negative Romberg's sign. Negative Hoffman's sign. Negative Babinski's Negative reverse radial reflex. Demonstrate a normal gait pattern. **MOTOR EXAM:** Upper and lower extremity motor strength grade testing is a 5 out of 5. **SPINAL EXAM:** Patient stands with an erect posture. They demonstrate a normal gait pattern. Negative for pelvic obliquity. There is significant spinal tenderness in the paraspinal muscles. Bilateral straight leg raise is negative. There are no Waddell sign's present. There is normal sensation to light touch seen in both upper and lower extremities. There is normal motor strength to upper and lower extremities. Reflexes in upper and lower extremities are normal at 2 out of 4. There is a negative Spurlings test and negative Lhermitte's sign. No long tract signs are present. The patient demonstrates good ROM with flexion, extension, side bending and rotation. Spinal motion is with pain. Slight grade 1 spinal listhesis noted. The rest of the levels appear normal. **Assessment:** As C3-4 on the left side. There is neuroforaminal stenosis secondary to hypertrophic facet joint versus possible callus from fracture. **Plan:** I recommend a CT myelogram with 1 mm sagittal cuts. I will see him back after.

08/19/2014: Office Visit. **HPI:** Reportedly the last 2 weeks pt seems to be worse with more headache in the back of the head rated s sharp pain 6-7/10 and starts in the morning. He continues to have some difficulty with neck movement, especially to the left. He continues to have numbness and pain down the side of the left arm mainly on the left forearm affecting the fingers. He has neck discomfort on movement of the neck with some nausea, diarrhea and vomiting the last few days. **Physical Exam:** There is some decreased movement on the left coared to the right and some mild tenderness over the base of the neck. Upper extremities have some decreased handgrip. **Assessment/Plan:** Recheck 3 weeks.

08/26/2014: Office Visit. **HPI:** Numbness is now in the hand only. Because patient was requested to have mammogram, he was declined on the basis patient's MRI of the neck shows only spondylolisthesis and spondylosis. He complains of weakness of the hand at times intermittent but doing better. He is eager to go back to work at a new job he has started and wants full release. **Physical Exam:** ROM good, mild tightness of the left trapezius muscle. Left arm shows no appreciable weakness. There is some sporadic numbness and sensation on pinprick left arm. Does not follow dermatome. No muscle atrophy. **Assessment/Plan:** Patient does not want to pursue further imaging study and is anxious to go back to work. Will release patient to full-duty. No risk at this point.

09/24/2014: Office Visit. **HPI:** Patient has increased headache after injury to his head in a car accident. Headache resolved until the last couple of visits. He has increased pain from the neck up. Patient has complaints of popping seems worse. Headache is gone but comes back. Neck pain continues and he has increased

difficulty. He continues to have numbness in the hands. **Physical Exam:** Sensitive in the neck. Movement results in severe pain. Mild muscle spasm. **Assessment/Plan:** Patient has trouble sleeping. Use amitriptyline 25 mg at bedtime. Tramadol for pain. No driving. Recheck in October.

11/06/2014: Office Visit. **HPI:** Patient continues to have pain in his neck radiating into his left arm. Hypertension, cervical radicular syndrome, Neck pain. **Assessment:** He had a previous fracture in which he had fractured the facet joint lamina on the left side. On the MRI scan, it is evident that it is causing some stenosis here. I have ordered a CT myelogram to further determine the stenosis as well as to assess the fracture. This has been denied. **Plan:** At this point, he continues to have pain. I do not feel that he is at MMI at this point. I feel he still needs treatment. I am going to order an epidural steroid injection to help him with the radiculopathy. We will refer him for this. In addition to this, I still recommend a CT myelogram of the cervical spine to assess the stenosis and the fracture site.

11/13/2014: UR. **Rationale for Denial:** The patient is a male who sustained an injury on xx/xx/xx secondary to a motor vehicle accident. He is diagnosed with cervical radicular syndrome and neck pain. A request is made for cervical myelogram with CT. The patient presented with headaches, neck pain and left arm paresthesia's with weakness. Cervical x-rays dated 3/31/14 demonstrated congenital block vertebra at C2-3 and straightening of the cervical spine which may reflect muscle spasm versus positioning. MRI dated 4/14/14 showed mild cervical spondylosis with no canal stenosis. There was mild to moderate left neural foraminal narrowing at C4-5 associated with primary spondylolisthesis. The study was slightly limited due to patient motion. Left upper extremity EMG/NCV on 5/13/14 revealed evidence of "bilateral" C5-6 radiculopathy and severe left median nerve entrapment across the carpal tunnel. Documented treatments included physical therapy and medications. The patient has been maintained on gabapentin and naproxen. The examination on 8/12/14 documented negative Spurling's test and normal neurologic findings in the upper extremities. Cervical x-rays obtained at that time showed congenital fusion at C2-3. At C3-4, there was slight grade 1 spinal listhesis. The rest of the levels appeared normal. On review of the MRI findings, there appeared to be significant hypertrophy of the facet joint versus possible callus from fracture at the left C3-4 causing neuroforaminal stenosis. As per 11/6/14 follow up, the patient continued to have pain in his neck radiating into his left arm. On assessment, he was indicated to have previously fractured the facet joint lamina on the left side. It was reportedly causing some stenosis based on the MRI scan. A plan for ESI was noted. CT myelogram was recommended to assess the stenosis and fracture site. However, the most recent records reviewed did not reflect findings of nerve root compromise or other pathology that would warrant validation with myelography. It was unclear how the proposed study would direct the course of the patient's management. With the above issues, the medical necessity of this request is not substantiated.

12/29/2014: UR. **Rationale for Denial:** This is an appeal of a cervical CT myelogram that was previously non-certified. The claimant is a male who was injured on xx/xx/xx, in a roll over motor vehicle accident. The claimant was

diagnosed with brachial neuritis or Radiculitis and cervicalgia. There was persistent neck pain with radiation into the left arm. Treatment included physical therapy, oral medications (naproxen and gabapentin), and an MRI on April 14, 2014, which suggested mild cervical spondylosis which was slightly limited secondary to motion. There was mild-to-moderate left foraminal narrowing at C4-C5 associated with primary spondylolisthesis. X-rays of the left shoulder documented no acute fracture or dislocation of the left shoulder. Electrodiagnostic testing on May 14, 2014, documented bilateral C5-C6 radiculopathy with severe left median nerve entrapment across the carpal tunnel. An evaluation on November 6, 2014, documented neck pain with radiation to the left arm. An epidural steroid injection was planned. A CT myelogram was recommended to assess for stenosis. This is a non-certification of an appeal of a cervical CT myelogram. The previous non-certification on November 12, 2014, was due to lack of nerve root compromise to warrant validation on myelography. The previous non-certification is supported. Additional records were not provided. A CT myelogram would not be supported unless there are significant changes in the physical examination or a contraindication to MRI. That is not documented in this claimant. There is no indication of re-injury or a contraindication to a repeat MRI. The request for an appeal of a cervical CT myelogram is not certified.

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

The previous adverse determinations are overturned. I would recommend a myelogram and ct scan. The MRI report is stated to be limited by motion artifact, and notes left neural foraminal narrowing at C4-5. His complaints are consistent with nerve root impingement. According to ODG Guidelines a myelogram and ct scan are helpful in surgical planning in regards to Foraminal Stenosis. I believe this exam would add significantly in evaluating the severity of nerve root impingement. For these reasons, Cervical Myelogram with CT 72240, 72125 is medically necessary at this time and should be approved.

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)**