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Notice of Independent Review Decision

DATE OF REVIEW: 12/28/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of Thoracic and Cervical CT Myelogram.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic 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)

The reviewer agrees with the previous adverse determination regarding the medical necessity of Thoracic and Cervical CT Myelogram.

A copy of the ODG was not provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant was reportedly assaulted on the date of injury. A workup included a thoracic MRI from July 10, 2014 that reported multiple levels of desiccation of discs. An MRI of the cervical spine from July 24, 2014 was noted to reveal a disk herniation at C5-C6 with nerve impingement and stenosis and a disc protrusion with cord impingement at C6-7. Bulges with cord abutment were noted at C3-4 and C4-5. There was ongoing neck pain documented as

of August 15, 2014. The claimant underwent a C 6-C 7 selective nerve on 9/10/14. On October 22, 2014, neck pain with radiation to the left arm was noted and the thoracic area was noted to be painful and tender. Waddell tests were positive. Cervical and thoracic tenderness was noted and the neuro. Exam was noted to be difficult due to pain reactions. Denial letters noted the lack of instability and/or progressive neurologic findings and the positive findings already evident on MRI.

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

There has not been any evidence of a poor correlation of physical findings with MRI studies despite the reported difficulty with obtaining a clear neurologic examination. In fact, there has been documented evidence of multiple positive Waddell tests. In addition, there has not been any evidence of any technical issues associated with the MRI scans. There has not been any evidence of progressive neurologic deficits. Therefore medical necessity has not been established as per the referenced guidelines.

Reference: ODG Neck/Upper Back Spine Chapter
Criteria for Myelography and CT Myelography:

1. Demonstration of the site of a cerebrospinal fluid leak (post lumbar puncture headache, post spinal 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)