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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Apr/01/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Cervical CT myelogram

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgery

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

[ ] Upheld (Agree)
[X] 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. It is the opinion of this reviewer that the cervical CT myelogram is medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: This patient is a female. On xx/xx/xx, an MRI of the cervical spine was obtained revealing anterior interbody fusions at C5-6 and C6-7. There was reversal of the normal cervical lordosis with a 1.4mm anterior subluxation of C4 on C5. There were facet hypertrophic changes at C2-3, C3-4 and postoperative changes were noted at C5-6 and C6-7. A bulging disc was noted at C7-T1. On 02/16/15, the patient was seen in clinic and it was noted she had undergone a discectomy and fusion to the cervical spine in 2000. That was not a work related event. However, in xx/xx , she tripped over a shoelace falling forward placing her face onto concrete. She sustained a jaw fracture. She was also recovering from a left rotator cuff surgery. Upon physical examination, testing showed weakness around the left shoulder with limitation in range of motion secondary to rotator cuff surgery. There are no deficits except for intrinsic muscle strength to the left hand which was atrophic and grade 4-. Sensory exam revealed decreased sensation along the dorsal forearm and the dorsum of the left little finger and ring finger. Reflexes were hypoactive but symmetric at the biceps, triceps, and brachial radialis.

X-rays showed alignment of the spine in the AP dimension, and flexion and extension x-rays showed no swelling and there was suggestion of a solid fusion at both interspaces. There was a 2mm anterolisthesis at C3-4 on C5 and a 1-2mm anterolisthesis of C7 on T1. The patient was to obtain the results of a neurological consultation, the results of electrodiagnostic studies, and a CT myelogram. It was noted that should there be evidence of radiculopathy from an unfused level, a surgical recommendation would be appropriate.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On 02/20/15, a notification of adverse determination was submitted non-certifying the requested CT myelogram but the rationale was not provided. On 03/09/15, a notification of reconsideration for adverse determination for the CT myelogram was submitted noting that there were objective signs of weakness on exam and there had been an MRI showing stenosis. It was noted it was unclear whether the

surgery would improve the patient's chronic pain.

Guidelines indicate that a CT myelogram may be considered reasonable for surgical planning especially in regards to the nerve roots, or if there is poor correlation of physical findings with MRI studies. The provider has indicated that the patient was to obtain the results of a neurological consultation, the results of electrodiagnostics, and a myelogram CT for review. Should there be evidence of radiculopathy coming from an unfused level, surgical recommendation was thought to be appropriate. In the absence of significant radiculopathy or instability, surgical intervention would not be indicated. Therefore, this exam is indicated as the provider was indicating that surgical recommendations would be based on this exam. A CT myelogram was to be performed for surgical planning. Therefore, it is the opinion of this reviewer that the cervical CT myelogram is medically necessary and the prior denials are overturned.

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)