

# US Decisions, Inc.

An Independent Review Organization

71 Court Street

Belfast, ME 04915

Fax: 207-470-1085

Notice of Independent Review Decision

**DATE OF REVIEW:** 04/22/2008

**IRO CASE #:**

## **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

MRI, Cervical

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

Board Certified Neurosurgeon with additional training in Pediatric Neurosurgery

## **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)

Upon independent review the reviewer finds that the requested MRI, Cervical is not medically necessary.

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

Adverse Determination Letters 3/12/08, 3/20/08  
ODG Guidelines and Treatment Guidelines  
Appeal of Denial Dr. 3/25/08  
MRI of the cervical spine report 12/1/06  
X-ray of the cervical spine report 10/6/06  
Clinic Note Dr. 3/4/08  
Dr. note 1/31/07

clinic note 1/29/07  
Progress Notes 12/28/06, 12/7/06, 10/25/06  
Letter To IRO by Mr. 4/7/08  
Clinic Notes 9/4/07, 3/1/07  
Neurological Consultation 1/30/07  
Prescription for Rehab Services 10/25/06  
Dr. clinic note 12/5/06  
Plan of Care 11/1/06  
Initial Evaluation 11/1/06  
Daily Notes 10/25/2006,  
PT note: 11/01/2006, 11/10/06, 11/13/06, 11/15/06, 11/17/06, 11/20/06, 11/21/06, 11/22/06,  
11/27/06, 11/29/06, 12/1/06, 12/4/06, 12/6/06

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

xyyear-old patient has a date of injury xx/xx/xx when he fell off a ladder and tore his rotator cuff. He complains of neck pain going into his shoulders and arms. He is also complaining of headaches and dizziness. His neurological examination is normal. An MRI of the cervical spine 2006 showed a small disc herniation at C3-C4, paracentral to the right, and a moderate broad-based disc at C4-C5. The provider is requesting a repeat MRI.

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

The MRI is not medically necessary. There is no evidence that the patient's pain has changed, nor have there been any new findings documented on physical examination. There is no reason to suggest that the MRI will show anything helpful in the care of this patient. The request is not consistent with the ODG criteria for MRI listed below, with him having already had an MRI that did not show any significant pathology.

### **References/Guidelines**

ODG ""Neck and Upper Back"

#### **Indications for imaging -- MRI (magnetic resonance imaging):**

- Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present
- Neck pain with radiculopathy if severe or progressive neurologic deficit
- Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present
- Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present
- Chronic neck pain, radiographs show bone or disc margin destruction
- Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury, radiographs and/or CT "normal"
- Known cervical spine trauma: equivocal or positive plain films with neurological deficit

**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)