C-IRO, Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 19, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI of the Cervical Spine without Contrast

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

MD, Board Certified Neurosurgeon

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity exists for MRI of the Cervical Spine without contrast.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters and Peer Review Reports, 6/24/08, 7/7/08
ODG Guidelines and Treatment Guidelines
MD, 7/25/08, 6/25/08, 6/11/08
Cervical Spine Series, 3/24/08
Lab Work Order, 6/11/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a female with a date of injury xx/xx/xx. She complains of excruciating neck pain radiating into the left arm requiring high doses of vicodin and neurontin. She has had a steroid dose pack as well as NSAIDs and activity modification. Neurological

examination shows giveway weakness in the left arm. Plain films of the cervical spine 03/24/2008 show multi-level degenerative changes. The provider is recommending a cervical MRI.

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

The cervical MRI is medically necessary. This patient has been symptomatic for many months and had several conservative measures, and yet remains with severe pain. Her pain is radicular in nature and she does have giveway weakness in her left arm. It is difficult to test true weakness in this setting because the patient is in so much pain, that she is diffusely weak. Nevertheless, the ODG, "Neck and Upper Back" chapter states that a cervical MRI is indicated for "chronic neck pain (after 3 months of conservative treatment), radiographs normal, neurologic signs or symptoms present". In this case, although one could argue as to whether or not "giveway weakness" is a neurologic sign, the pain radiating into the left arm is certainly a neurologic symptom. Therefore, the patient meets the ODG criteria for a cervical MRI. The reviewer finds that medical necessity exists for MRI of the Cervical Spine without contrast.

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**

- [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)**