

## **I-Resolutions Inc.**

*An Independent Review Organization*

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### Notice of Independent Review Decision

**DATE OF REVIEW: SEPTEMBER 22, 2008**

**IRO CASE #:**

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

Cervical MRI

**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 does not exist for Cervical MRI.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 8/11/08, 8/29/08

ODG Guidelines and Treatment Guidelines, Neck and Upper Back Chapter

MD, 8/28/08, 8/8/08, 4/16/08, 4/2/08, 2/15/08, 1/9/08, 1/2/08, 12/26/07, 3/3/08, 3/19/08, 12/18/07, 12/13/07, 12/5/07, 11/28/07, 11/21/07, 11/15/07

MD, 5/9/08

MD, 7/31/08, 7/23/08

MRI of the Thoracic Spine w/o contrast, 4/7/08

PT, 1/3/08, 12/28/07, 12/21/07, 3/5/08, 2/29/08, 3/26/08, 3/19/08, 11/27/07, 12/5/07, 11/19/07

Cervical Spine, 2 Views, 11/15/07

Thoracic Spine, 2 Views, 11/15/07

Letter from Mother of Patient, 9/8/08

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

The claimant is a xx year-old female with a date of injury xx/xx/xx, when carrying some files, she twisted her head and felt a sharp pain shoot through her neck and upper left shoulder. She complains of continued discomfort in her upper back between the scapulae. She has refused injections or medications. She has undergone PT. Her neurological examination is normal. On 07/31/2008, she underwent a designated doctor exam and was found to have reached MMI with an impairment rating of 0%. On 11/15/2007 she underwent plain films of the cervical spine, which revealed a flexion deformity involving the cervical spine. This may be secondary to position. An MRI of the thoracic spine was performed 04/07/2008 and showed a central disc protrusion at C6-C7 with cord impingement. According to the provider, the patient abandoned care in 04/2008. The current request is for MRI of the cervical spine.

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

The MRI of the cervical spine is not medically necessary. According to the ODG, "Neck and Upper back" chapter, a cervical MRI is indicated for: Chronic neck pain (after 3 months conservative therapy), 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 with equivocal or positive plain films with neurological deficit.

The claimant's condition meets none of these criteria. Her pain is in the upper thoracic area. She has no neurologic findings or symptoms. There is a protruding disc at C6-C7 (seen on the thoracic MRI), but there is no indication that she is symptomatic from this. She does not have axial neck pain and is not myelopathic. The reviewer finds that medical necessity does not exist for Cervical MRI.

**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)