



IMED, INC.

1701 N. Greenville Ave. • Suite 202 • Richardson, Texas 75081
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584
e-mail: imeddallas@msn.com

Notice of Independent Review Decision

DATE OF REVIEW: 08/20/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Repeat MRI without contrast, cervical spine

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

Texas Board Certified Orthopedic Surgeon

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. IRO referral form
2. Results CT of the head without contrast 10/09/07
3. Results cervical spine radiographs 3 views 11/09/07
4. Notice of disputed issues and refusal to pay benefits 12/06/07
5. Results MRI cervical spine 12/27/07
6. Outpatient clinic note dated 02/08/08 Dr.
7. Pre authorization report 03/06/08 regarding outpatient physical therapy
8. Initial consultation 04/22/09 , D.C.
9. Initial consultation 04/30/09 , D.C.
10. Rehabilitation request 05/19/09 , D.C.
11. Pre authorization determination dated 07/07/09 Dr. regarding non-authorization cervical MRI without contrast
12. Reconsideration determination 07/27/09 , D.C., regarding repeat MRI without contrast cervical spine
13. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a xx-year-old female whose date of injury was listed as xx/xx/xx. Records indicate the employee is a and attempted to sit in a chair when the chair went out from under her causing her to fall on the left side of her body injuring her low back, neck and left shoulder.

Plain radiographs of the cervical spine dated 10/09/07 reported vertebral bodies were well aligned and disc space was maintained with minimal spondylitic changes present. No fractures were seen. An MRI of the cervical spine performed on 12/27/07 and reported the cervical spine was normal without herniated nucleus pulposus, foraminal narrowing, or spinal stenosis. No abnormal signal was seen in the cord.

The employee was seen by Dr. on 02/08/08 for a chief complaint of left arm and shoulder pain. The employee reported that approximately two months previously a chair gave out from under her and she fell back on her left arm. She did not recall having any bruising but has continued to experience pain in the arm as well as in the anterior aspect of the shoulder. The physical examination reported the employee to have full range of motion of the shoulders. She did not seem to be that tender. There was a little bit of tightness of the trapezius. Dr. did not detect any numbness or atrophy. He did not detect any loss of strength or weakness. Review of the MRI revealed a very small supraspinatus tear as well as a very small displaced labral tear. The employee's cervical spine was essentially normal. Dr. 's impression was strain shoulder and neck. Dr. referred the employee to physical therapy for strengthening and range of motion exercises, and prescribed Flexeril and Norco as well as some Motrin.

Initial consultation report by , D.C., dated 04/30/09 indicated the employee presented for an injury sustained on xx/xx/xx when her chair went out from under her. The employee reported that she was treated at the hospital and had x-rays and diagnostic studies on the day of the injury. The employee continued to work as an but reported experiencing moderate difficulty with job tasks due to low back pain, neck pain, and shoulder pain. Upon examination, the employee was 5 feet tall and weighed 240 pounds. Deep tendon reflexes were reported as 1+/5+ in the bilateral biceps, triceps, brachial radialis, patellar, and Achilles. Sensory testing reported left upper extremity C5-C6 hyperesthesia and left lower extremity L5-S1 hyperesthesia. The neurologic test was positive for numbness and tingling primarily in the left arm and left leg. It was negative for weakness and negative for loss of balance. Orthopedic testing reported cervical compression caused severe pain in the lower cervical region. The employee vomited following the testing. She reported this had happened before. Further cervical testing was recommended. Cervical range of motion reported flexion 30 degrees and extension 10 degrees with pain, lateral flexion left 20 degrees and right 30 degrees, and rotation right 30 degrees and left 15 degrees.

Lumbar range of motion flexion 80 degrees and extension 10 degrees with pain. There was moderate tenderness to palpation in the cervical paraspinal region of the lower cervical areas with corresponding spasm of the left cervical and thoracic paraspinal musculature. There was definite tenderness to palpation of the left lumbar region with

spasm of the thoracolumbar musculature on the left side. Strength testing reported weakness of the left EHL compared with the right.

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

A request for cervical MRI without contrast was nonauthorized on 07/07/09 by Dr. . Dr. noted that records did not establish medical necessity in the form of progressive radiculopathy or myelopathy. A reconsideration request for repeat MRI of the cervical spine was nonauthorized on 07/27/07 by , D.C. Documentation submitted for review did not include the rationale for this nonauthorization.

The request for MRI of the cervical spine without contrast is not supported as medically necessary. Records indicate the employee was injured when she attempted to sit down and the chair went out from under her causing her to fall on the left side of her body. The employee continues to work as but reports experiencing moderate difficulty with job tasks due to low back pain, neck pain, and shoulder pain. An MRI of the cervical spine performed on 12/27/07 was reported as normal without herniated nucleus pulposus, foraminal narrowing, or spinal stenosis. There was no abnormal signal in the cord. There was no evidence of progression of neurologic deficit that would support the need for repeat cervical MRI, particularly in light of the previous cervical MRI which was completely normal.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ODG Treatment Integrated Treatment/Disability Duration Guidelines, Neck and Upper Back chapter, Online Version

Magnetic resonance imaging (MRI)	Not recommended except for indications list below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging. Patients who do not fall into this category should have a three-view cervical radiographic series followed by computed tomography (CT). In determining whether or not the patient has ligamentous instability, magnetic resonance imaging (MRI) is the procedure of choice, but MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. (Anderson, 2000) (ACR, 2002) See also ACR Appropriateness Criteria™ . MRI imaging studies are valuable when physiologic evidence indicates tissue insult or nerve impairment or potentially serious conditions are suspected like tumor, infection, and fracture, or for clarification of anatomy prior to surgery. MRI is the test of choice for patients who have had prior back surgery. (Bigos, 1999) (Bey, 1998) (Volle, 2001) (Singh, 2001) (Colorado, 2001) For the evaluation of the patient with chronic neck pain, plain radiographs (3-view: anteroposterior, lateral, open mouth) should be the initial study
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	<p>performed. Patients with normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging. If there is a contraindication to the magnetic resonance examination such as a cardiac pacemaker or severe claustrophobia, computed tomography myelography, preferably using spiral technology and multiplanar reconstruction is recommended. (Daffner, 2000) (Bono, 2007)</p> <p>Indications for imaging -- MRI (magnetic resonance imaging):</p> <ul style="list-style-type: none">- 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 (sprain), radiographs and/or CT "normal"- Known cervical spine trauma: equivocal or positive plain films with neurological deficit
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