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DATE OF REVIEW:
Jun/29/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Repeat Cervical MRI without dye (72141)

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

REVIEW OUTCOME:

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

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
ODG Guidelines and Treatment Guidelines
MRI cervical spine, 10/16/07
Office notes, Dr. 04/30/08, 05/14/08, 10/09/08, 10/30/08, 12/05/08, 01/02/09, 01/21/09, 03/11/09, 04/29/09
Operative report, Dr. 10/06/08
PT notes, 03/02/09, 03/09/09
Peer reviews, 03/19/09, 04/07/09, 05/19/09, 06/05/09

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a male with a work injury of xx-xx-xx. A 10/16/07 MRI of the cervical spine report was provided for review demonstrating multilevel cervical spondylosis and osteoarthritis causing spinal canal stenosis C3-4, C4-5, C5-6, moderate central disc protrusion C4-5 compressing the ventral spinal cord and osteophytic neural foraminal stenosis throughout the cervical spine.

Subsequent records deal with treatment of a right shoulder injury by Dr. beginning on 04/30/08. MRI of the shoulder showed a full thickness rotator cuff tear and the claimant underwent right shoulder arthroscopic decompression, mini arthrotomy, rotator cuff repair, and release of the coracoacromial ligament on 10/06/08. The claimant underwent post op rehab for the shoulder.

At the 01/21/09 visit with Dr., the claimant was doing well with his shoulder but was complaining of neck pain. Dr. noted that the claimant had been followed in the past for cervical injuries to his neck. He had tenderness in the paracervical musculature. The claimant was prescribed Medrol and physical therapy for the cervical spine. On 03/11/09 the

claimant had persistent neck pain and difficulty with activity. There was persistent bilateral cervical paraspinous muscular tenderness and spasm with limited mobility in all planes.

The diagnosis was chronic cervical strain with discogenic syndrome. A cervical MRI was ordered. On 04/29/09 Dr. again documented persistent neck pain that radiated to the top of both shoulders and pain with cervical range of motion and palpable tenderness in the lower paracervical musculature. The impression was chronic cervical discogenic syndrome. Cervical MRI was ordered and denied on multiple peer reviews.

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

Review of the medical records supports that the claimant is a gentleman with reported chronic cervical discogenic syndrome with a reported injury of 01/10/00, mechanism not provided. MRI 10/16/07 showed multilevel degenerative changes and stenosis at C3-4, 4-5, 5-6 with a moderate protrusion at 4-5 compressing the ventral cord. His shoulder condition was treated with injection and MRI and rotator cuff repair. His neck was treated with physical therapy, Medrol-Dosepak by Dr. 01/21/09. He had persistent reports of pain in his neck, difficulty with activities with spasm. Dr. recommended repeat MRI on 03/11/09. Dr. on 04/29/09 noted persistent reports of neck pain radiating to the top of bilateral shoulders. On physical exam he reported pain with range of motion of the cervical spine and tenderness. He recommended an MRI to evaluate chronic cervical discogenic syndrome. This was peer reviewed and denied on four separate occasions due to lack of physical examination findings showing a progressive neurologic deficit or spinal surgeon evaluation.

Based solely on review of the medical records provided and evidence based medicine ODG guidelines the reviewer would not find the medical necessity of a cervical MRI and would support the MRI be denied of the cervical spinal canal and contents. The claimant is reporting neck pain with a known degenerative process. There is no radicular pain, no progressive neurologic deficit and no recent x-rays to confirm advanced degeneration, motion segment instability, or spinal listhesis.

Based on the above issues and based solely on review of the medical records provided, evidence based medicine, and ODG guidelines the proposed MRI cannot be considered medically necessary and appropriate at this time. The reviewer finds that medical necessity does not exist for Repeat Cervical MRI without dye (72141).

Official Disability Guidelines Treatment in Worker’s Comp 2009 Updates: 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 (sprain), 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-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)