



# Lumetra

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**DATE OF REVIEW:** 5/20/09

**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**

Certified by the American Board of Neurological Surgery

**REVIEW OUTCOME**

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
Xx/xx/xx		Prospective	346.9	72141	Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Physicians notes from 4/14/08 to 4/9/09

MRI report dated 4/3/09, 2 reports dated 4/18/08

Procedure note dated 5/6/08

Electrodiagnostic Study dated 12/8/08

Official Disability Guidelines cited – Neck Chapter Indications for Imaging

## **PATIENT CLINICAL HISTORY:**

This claimant was injured on xx-xx-xx when an elevator cable broke and the elevator fell approximately 14 stories. The claimant was jolted enough to jump in the air when the car stopped and there was apparent loss of consciousness. According to the consultation note of 4/14/08, there was initial headache that lasted for 2 weeks and is now more intermittent and initial radiographs at the Emergency Room are reported to be unremarkable. Physical examination on 4/14/08 reports pain elicited with extension and lateral rotation. Negative Spurling's test is noted and there is tenderness to palpation on the left side of the cervical spine. Sensation in the upper extremity is decreased over the left ulnar distribution compared with the right side. Significant weakness is noted with abduction of the fingers and thumb. Reflexes are equal and symmetric in the upper extremities and lower extremity evaluation demonstrates exquisite tenderness over the right medial joint line of the right knee with pain on flexion and extension.

MRI of the cervical spine dated 4/18/08 reports straightening of the usual cervical lordosis with mild disc dehydration from C2-C6. Facet hypertrophy is noted on the right at C2-3 with mild neural foraminal stenosis. Mild facet hypertrophy is noted at the C3-4 level bilaterally. No cord compression or central or neural foraminal stenosis is noted.

The evaluation on 4/24/08 states the claimant has intermittent headaches that are of migraine type and states that they are one sided, severe and do not promote vomiting but promote nausea, some photophobia and no phonophobia. Physical examination reports no evidence of cranial trauma. The neck is stiff and tight, left greater than right, with localized area of spasms bilaterally. DTRs are equal and symmetric in all extremities with normal motor strength throughout except for slight decreased grip strength to the left.

According to a physician note of 4/24/08, an EMG/NCS study of the left upper extremity was performed and reported to be unremarkable. The claimant underwent an epidural steroid injection to the L5-S1 level on 5/6/08. The claimant reported minimal relief with pain returning approximately 12 hours after the injection. The claimant was started on Lyrica on 12/17/08 as recent EMG studies reported no active radiculopathies in the lower extremities.

Follow up on 1/20/09 noted that the claimant stopped Lyrica because it was giving her flashbacks to the injury. The claimant also complains of sleep problems. The claimant was given refills of Soma, prescribed Restoral for sleep, and the Paxil CR prescription was increased to 37.5 mg bid.

Follow up on 02/23/09 noted that the claimant is experiencing depression and having cognitive problems with memory and sedation, and has had apparent tonic colonic activity at night. The claimant has leg twitching that continues to whole body

convulsing. A single episode produced incontinence. The claimant was switched to Prosom as a sleep aide.

Follow up on 03/05/09 noted that the claimant describes seizures in the legs and arms. The claimant states the shaking is uncontrollable and sometimes finds herself on the floor with a strong headache afterward. The claimant is noting more forgetfulness and has strong emotional changes and dizziness. The claimant was started on Cymbalta 30 mg and was referred for MRI of the brain.

MRI of the brain dated 4/3/09 reports 3 small foci of hypersensitivity in the periventricular white matter of a nonspecific finding. The appearance is nonspecific and can be seen with microvascular change, demyelinating processes or migraines. No lesions are noted within the corpus callosum or brain stem. No MR evidence of edema or hemosiderin and there is no mucosal thickening of the left maxillary sinus.

According to a clinical note of 4/9/09 findings on MRI of the brain are not related to vascular disease but to the head injury that she sustained and also with migraines since the injury. The patient was started on Topamax.

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

In the Reviewer's opinion, the requested cervical MRI is not recommended as medically necessary. The submitted cervical MRI on 4/18/08 reports facet hypertrophy at the C2-C4 levels with no other clear abnormalities. The claimant was diagnosed with post concussion syndrome and had complaints of paresthesias in the left upper extremity; however, electrodiagnostic studies were reported to have been performed on 04/24/08 which showed no evidence of radicular symptoms and the physician opined that the claimant's paresthesia in the left arm and upper back are more related to myofascial pain syndrome. There are no other documented neurological deficits of a progressive nature in the submitted clinical documentation. More recent physical examinations are focused on the lower extremities and treatment for her insomnia and headaches. ODG guidelines require evidence of neurological deficits in the upper extremities to indicate the medical necessity for repeat MRI studies of the cervical spine. Based on the submitted clinical documentation and ODG guidelines, the request of MRI of the cervical spine is not indicated.

#### References:

ODG Neck and Upper Back Chapter

Patients who are alert, 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.

**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)