

# MATUTECH, INC.

PO BOX 310069  
NEW BRAUNFELS, TX 78131  
PHONE: 800-929-9078  
FAX: 800-570-9544

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## Notice of Independent Review Decision

**DATE OF REVIEW:** June 1, 2010

**IRO CASE #:**

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

MRI cervical spine without contrast

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

Neurosurgeon, F.A.C.S.

**REVIEW OUTCOME**

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

Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Utilization reviews (04/16/10 – 03/13/10)
- Utilization reviews (04/16/10 – 03/13/10)
- Office visits (02/25/09 – 05/06/10)
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- Office visits (02/25/09 – 05/06/10)
- Diagnostic tests (01/16/07 – 04/29/09)

**ODG has been utilized for the denials.**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who was involved in a motor vehicle accident on xx/xx/xx, injuring her neck.

**2007 – 2008:** On January 16, 2007, M.D., obtained a magnetic resonance imaging (MRI) of the cervical spine. The study revealed: (1) Minimal retrolisthesis of C5 on C6. Modic type II degenerative endplate changes at

C2-C3 and C3-C4. Anterior vertebral endplate osteophytes demonstrated from C4-C5 through C6-C7. Diffuse degenerative disc desiccation changes seen throughout with disc space height loss from C3-C4 through C6-C7. A moderate degree of congenital spinal canal stenosis was seen. (2) At the C3-C4 level, at least moderate bilateral neural foraminal outlet narrowing due to uncovertebral hypertrophic changes primarily. There was a broad-based disc osteophyte complex, which caused moderate central canal narrowing up to 7 mm anterior posterior. (3) At the C4-C5 level, moderate right neural foraminal outlet narrowing due to uncovertebral spurring. A broad-based disc osteophyte seen at this level causing moderate central canal narrowing up to 7 mm anterior posterior. (4) At the C5-C6 level, a broad-based disc osteophyte complex causing moderate central canal narrowing up to 8 mm anteroposterior. Moderate-to-severe bilateral neuroforaminal narrowing due to uncovertebral spurring. (5) At the C6-C7 level, moderate-to-severe left neural foraminal narrowing due to uncovertebral spurring. There was a small disc osteophyte complex causing mild narrowing of the central canal measuring 9 mm anteroposterior. (6) There was a small amount of fluid within the sphenoid sinus.

In October 2008, DXA scans of the lumbar spine and the left hip was normal.

**2009:** M.D., noted significant positional mechanical low back pain with left-sided radicular pain extending into the top of the foot. The patient had undergone a number of non-spinal surgeries for complications. She was limited to conservative treatment secondary to severe peptic ulcer disease, but had failed to see any significant improvement over the last two years. History was significant for hypothyroidism, arthroscopy of the left knee and bilateral shoulders, lumbar laminectomy in 1995, and right shoulder rotator cuff repair. Examination revealed brisk ankle jerks on the right and mildly decreased on the left, dysesthesias over the dorsum of the left foot and to a much milder degree on the right, decreased pedal pulses along the lateral aspect of the left foot, weakness with dorsiflexion of the left foot and great toe, tenderness over the left sacroiliac (SI) joint and pain with external and internal rotation of the left hip. Dr. assessed evidence of a dysfunctional joint system at the last caudal segment, prescribed Robaxin in addition to ongoing amitriptyline and Cymbalta and referred the patient for further diagnostic studies.

X-rays of the lumbar spine revealed severe degenerative disc disease (DDD) at L5-S1. MRI of the lumbar spine revealed: (1) Status post left hemilaminectomy and discectomy at L5-S1. There was a disc bulge with concomitant endplate spurring eccentric to the left, mild facet arthrosis, and marked loss of disc height resulting in moderate-to-severe narrowing of the left neural foramen and scar tissue in the epidural space to the left of midline. (2) At L4-L5, a small bulge eccentric to the right indenting the ventral thecal sac resulting in borderline central canal stenosis and mild-to-moderate narrowing of the right neural foramen. (3) At L2-L3, there was a small bulge eccentric to the right resulting in minimal foraminal narrowing bilaterally, right greater than left.

Computerized tomography (CT) of the lumbar spine revealed: (1) Severe DDD at L5-S1. The amount of impingement from disc bulging or disc protrusion and/or spurring was unclear. However, there did appear to be soft tissue density in the left neuroforamina that could be impinging on the left L5 nerve root. (2) Probable

moderate stenosis at L4-L5 secondary to disc bulging, thickened ligamentum flavum and hypertrophic facet joint arthropathy.

MRI of the thoracic spine revealed: (1) Mild disc dehydration throughout without significant disc bulge or protrusion. (2) Small disc osteophyte complexes in the lower cervical spine at C5-C6 and C6-C7.

Dr. noted worsening weakness and decided to proceed with a redo decompression and stabilizing fusion procedure. He noted the MRI of the cervical spine revealed no evidence of myelopathy although she did have some significant cervical stenosis. He did not recommend any further work up.

X-rays of the cervical spine revealed: (1) Straightening with loss of normal lordosis. (2) Moderately severe DDD from C3 to C7. (3) A 2-mm retrolisthesis of C5 on C6 most likely secondary to degenerative facet joint disease.

In April, Dr. noted she had on and off non-radiating neck pain that limited her lifestyle since the traumatic event of 2006. This had progressed over the last month and was overshadowing her low back concerns. Dr. recommended aggressive efforts of maximizing conservative measures, ordered CT imaging of the cervical spine and referred her to a chronic specialist for cervical epidural steroid injection (ESI) and physical therapy (PT).

**2010:** On April 9, 2010, Dr. noted bilateral hand paresthesia along with left leg paresthesias and some urinary urgency. He assessed worsening cervical myelopathy and recommended a CT of the cervical spine without contrast.

On April 16, 2010, MRI of the cervical spine was non-authorized. The rationale for the denial is not available on the records.

On May 6, 2010, Dr. issued a letter of medical necessity stating the patient was now describing symptoms worrisome for cervical myelopathy. Unfortunately, she had no current images to properly evaluate this. Given the magnitude of problems associated with cervical myelopathy, this would have to take precedence to her complaints of mechanical low back pain. Previous MR images from 2007 showed very significant stenosis at the C5-C6 level with some laxity on upright dynamic images from nearly a year ago. Hence he recommended that she obtain new imaging and return to clinic within a week for further evaluation.

On May 13, 2010, M.D., denied the appeal for an MRI of the cervical spine without contrast based on the following rationale: *"The patient was complaining of neck pain with paresthesias in her bilateral hands with frequently dropping items and intermittent Lhermitte's. The clinical note submitted for review dated April 9, 2010, states the patient is recommended for an MRI scan of the cervical spine as well as for plain films. It was stated in the clinic note that the patient has had a prior MRI; however, this was not submitted for review. It is unknown if the plain films are performed as they were not submitted for this review. Therefore, based on the current guidelines, the request for an MRI of the cervical spine without contrast is non-certified."*

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

*I have reviewed the medical records provided to me concerning the patient. There are the records of a motor vehicle accident, mention of Dr., a MRI of 1/16/07, 11/20/07, bone Densitometry of 10/23/08, the medical records of Dr., Dr. –Hospital, epidural steroid requests, correspondence as well as numerous x-ray and imaging reports.*

*I will try to address those questions posed in the correspondence received 5/25/10.*

*An appeal was requested for a denied MRI of the cervical spine without contrast requested by Dr..*

*The patient apparently was involved in a motor vehicle accident on xx/xx/xx. She was seen, treated and followed conservatively and in January 2007 had a cervical MRI.*

*She has had off and on treatment for it; however, recently Dr. has been worried about the possibility of progressive myelopathy.*

*The findings for myelopathy are absent in that she has complaints though no findings of long tract signs, hyperreflexia, weakness or other abnormalities.*

*The MRI is requested because of the prior MRI demonstrating severe stenosis and degenerative disc disease.*

*While the MRI is indeed indicated based on ODG Guidelines, in my opinion, it is not related to the motor vehicle accident of xx/xx/xx.*

*The changes are all very chronic in nature, all of which are progressive and certainly 3 ½ years later, are related to the progression of the spondylotic degenerative disc disease and not the motor vehicle accident. More likely than not, the motor vehicle accident was a soft tissue injury as none of the changes are of an acute nature.*

*With the progression of this condition, certainly worsening could occur and will occur and for that reason the MRI is indicated, but relative to the etiology, it is not from a single episode.*

*Were this condition to have been symptomatic, the medical records I have certainly do not document a progressive change or even progressive treatment as most of the progressive treatment I have reviewed is for low back problems for a degenerative and mechanical nature.*

*With that in mind, in my opinion, I believe that the MRI of the cervical spine is indeed indicated though in my opinion, unrelated to the motor vehicle accident that occurred on xx/xx/xx.*

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

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT  
GUIDELINES**