



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 5/13/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a repeat MRI w/o contrast - cervical spine.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. This reviewer has been practicing for greater than 10 years in this field.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a repeat MRI w/o contrast - cervical spine.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
xxxxx and xxxxx

These records consist of the following (duplicate records are only listed from one source): Records reviewed from xxxxx: email – 1/30/08, xxxxxxx – 1/30/08; DWC 1 – 1/18/08; xxxxx Pre-auth – 2/6/08, 3/6/08, & 8/13/08, Office Notes – 1/31/08-4/17/09, Patient Profile – 11/21/08 & 3/11/10, MRI report – 6/11/08 & 12/19/08, X-ray Reports – 1/31/08, WC Verification for Diagnostic/Surgical Procedures – 6/18/08 & 4/28/09; MD Peer Review – 12/21/08 & 1/28/09; MD MRI report – 4/19/08; MD Peer Review – 4/21/10. Records reviewed from xxxxxx: Office Notes – 1/21/09-4/14/10.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient was injured on xx/xx/xxxx while attempting to sit on a jump seat in an aircraft. She apparently fell striking the back of her head, tailbone, lower back, and left elbow on an unknown object. Her Employer's First Report of Injury report indicated that diagnoses of multiple arm contusion, neck sprain, and concussion were made.

On January 31, 2008, the patient began treatment with M.D. Dr. noted limited range of motion of the neck, intact upper extremity strength and sensation, and normal upper extremity reflexes. He diagnosed cervical strain as well as a lumbar strain, anemia, and peptic ulcer disease. He recommended treatment with physical therapy, Celebrex, Flexeril, and Vicodin.

The patient began a physical therapy program on February 6, 2008. She did make some improvement, but continued to complain of cervical spine problems. An MRI of the cervical spine performed on April 19, 2008 showed a slightly inferiorly projecting small posterior central disk protrusion at C5-6, a right C4-5 disk protrusion, and moderate degeneration of the disk at C6-7.

On June 11, 2008, the patient began treatment with M.D., a neurosurgeon. She continues under Dr. care. His initial evaluation showed normal deep tendon reflexes, strength, and sensation. He noted the MRI findings previously described.

Epidural steroid injections were recommended, but refused by the patient. Dr. continued to follow the patient at approximately four to eight week intervals from the time he initially saw her until his last evaluation on April 14, 2010. The injured worker continued to complain of neck pain as well as pain in the dorsal area. Radiation to both shoulders was described from time to time. On November 21, 2008, Dr. noted hyperactive deep tendon reflexes, a positive Hoffman's sign on the left, and sustained clonus, greater on the left than the right. His impression was that there was spinal cord irritation and he recommended a repeat MRI evaluation. This evaluation reportedly showed a herniation of the C5-6 disk producing mild compression of the spinal cord without producing a change in the spinal cord signal.

Peer reviews were provided by M.D. on December 21, 2008 and January 28, 2009. Dr. felt that the patient's repeat MRI performed on December 19, 2008 had shown that the disk herniation at the C5-6 level was somewhat larger and slightly more prominent and clearly indented and displaced the cervical spinal cord. He recommended consideration of surgery. Dr. planned and recommended evaluation for possible surgery including EMG and myelography.

The patient refused epidural steroid injections and surgery and according to available medical records, showed some improvement in her neck pain.

On March 11, 2010, Dr. noted that there were no changes in the injured worker's complaints or physical findings. The injured worker was anxious to return to work, but Dr. was reluctant to return her to work to the required full duty, apparently feeling that there was risk for further spinal injury if she could not safely perform her full duties. He requested a third MRI on March 11, 2010 to be certain there was no abnormality of the spinal cord and no significant compromise.

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

This injured worker had a documented injury to her cervical spine in a work related accident on January 18, 2008. She had persisting neck symptoms and had a MRI of the cervical spine performed on April 19, 2008. This did show a protruding disk at the C5-6 level. She developed brisk reflexes, positive Hoffman's response, and clonus and had a repeat study on December 19, 2008. This apparently showed progression of the disk herniation producing compression of the spinal cord. Aggressive therapy was recommended including evaluation for possible surgery, but the injured worker refused all treatment except for physical therapy and medications.

Over the years following her injury, she showed some improvement in the neck symptoms. On Dr. most recent evaluation on April 14, 2010, overall neck pain improvement was noted. There was no radicular pain into the arms and no upper extremity numbness, tingling, or weakness. Strength was 5/5. Deep tendon reflexes were 3 to 4. Clonus was noted on the left side. The sensory exam was said to be normal.

This injured worker has known disk herniation at C5-6 with cervical spinal cord involvement. Although she has noted some improvement in her discomfort, she continues to have brisk reflexes and clonus is described. There is no evidence of progression of symptoms and as a matter of fact, her symptoms seem to be improved. According to the ODG Guidelines, repeat MRI scans for the cervical spine are indicated only if there is a "progression of neurologic symptoms". There is no evidence in records reviewed that there is a clinical reason to repeat this study. Since there is known disk herniation and spinal cord compression without progression of symptoms, there is no indication or medical necessity for a repeat MRI study, according to the ODG Guidelines.

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)