

# Core 400 LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Feb/07/2011

**IRO CASE #:**

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

MRI thoracic spine

**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:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates; Low Back- MRI

11/29/10 Review: Dr.

12/30/10 Review: MD

01/27/10 CT scan

01/28/10 MRI: Thoracic and Lumbar

01/29/10 XR: Cervical

02/10/10 Review

02/11/10 Office note Dr.

10/08/10 DDE, Dr.

10/23/10 Office note Dr.

11/01/10, DC

11/08/10 Dr. office note

11/29/10

01/03/11

12/01/10 Office note Dr.

12/03/10 Office note Dr.

12/01/10 Dr., D.C., Appeal Letter for Thoracic MRI

12/21/10 Appeal Letter

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male with a reported injury on xx/xx/xx when he was cutting an iron canister with a torch and the contents of the canister were expelled. A piece of metal struck the claimant in the neck and upper back and the claimant was found on the ground unconscious. The claimant was seen in the emergency department with diagnoses of non-displaced bilateral C7 and T1 transverse process fractures; non-displaced T1 and T2 spinous process

fractures; compression fractures at T8, T10, T12 and L1; spinous process fractures at T8 and T9; right apical pneumothorax; and bilateral first rib fractures; and right fourth through sixth rib fractures. The claimant was admitted to the hospital for four to five days without those records provided for review. Cervical CT evaluation on xx/xx/xx showed the non-displaced C7-T2 fractures with normal cervical alignment and subcutaneous emphysema around the posterior back soft tissues on the right by the pneumothorax. Reference was made to chest, abdominal and pelvis CT evaluation also conducted on xx/xx/xx that noted the rib and lower thoracic fractures.

Thoracic and lumbar MRI evaluations were performed on 01/28/10 with additional findings of T5-6 small central disc protrusion that caused mild flattening of the ventral cord, extensive edema in the posterior paraspinous musculature, T8 minimal disc bulge, moderate discogenic degenerative changes in the lower lumbar spine without significant spinal stenosis, posterior annular fissures at L3-4, L4-5 and L5-S1 with associated small disc protrusions most prominent at L5-S1, mild facet degeneration at L5-S1, mild canal narrowing at L4-5 and tiny right paracentral disc protrusion at L2-3. Cervical radiographs done on 01/29/10 noted C1-4 were in satisfactory alignment without evidence of subluxation. An extended stay review dated 02/10/10 indicated the claimant was to be moved from IMU to the acute orthopedic floor that day, the claimant was wearing a cervical collar, taking Norco and they were waiting for physical therapy clearance. Dr. saw the claimant on 02/11/10 with notation the claimant continued use of rigid cervical and body braces. Physical examination demonstrated equal reflexes, intact sensation and 5/5 strength. Recommendation was made to continue use of Vicodin and Ibuprofen with no activity for two weeks.

A designated doctor evaluation conducted on 10/08/10 noted the claimant was placed at maximum medical improvement on 08/26/10 with a fifteen percent impairment rating. It was noted the claimant had treated with physical therapy, medications and electrical stimulation. Reference was made to a functional capacity evaluation from 09/22/10 that indicated the claimant's required physical demand level was heavy and the claimant was currently functioning at a sedentary level. The claimant had ongoing complaints of neck, shoulder, arm, upper back, mid back and low back pain. Physical examination demonstrated cervical, thoracic and trapezial tenderness; limited cervical motion with negative Spurling and Adson's; negative apprehension, Neer, Hawkins and cross body testing; 5/5 strength; difficulty with heel walking; negative straight leg raises; and limited lumbar motion. The reviewer continued to recommend maximum medical improvement with fifteen percent impairment. Dr. saw the claimant on 10/23/10 and noted the claimant had back surgery in 2003 from which he recovered well. Recommendation was made for use of Celebrex, Ultracet and to continue physical therapy. Dr. saw the claimant for chiropractic management. On 11/01/10 Dr. saw the claimant on 11/0/10 for continued mid back pain that was associated with activity, as well as occasional numbness in the bilateral lower extremities. Physical examination demonstrated marked tenderness over the lower thoracic spine with normal lower extremity strength. Recommendation was made for repeat thoracic MRI evaluation to ensure there was no further bone marrow edema or disc injury. The repeat thoracic MRI study was denied twice on peer review. On 12/01/10 Dr. indicated the claimant had increased cervical pain with severe occipital pain. On 12/03/10 Dr. noted diagnoses of displaced intervertebral cervical disc without myelopathy, intervertebral thoracic disc with myelopathy and neuralgia, neuritis and radiculitis. Dr. also recommended thoracic spine MRI evaluation. An appeal letter for the thoracic MRI was done on 12/21/10 with notation the claimant has had thoracic pain since the day of injury; had a positive Soto Hall and anterior to posterior chest compression test; the claimant had worsening radiculitis pain; and there were palpatory findings of hypermobility. Recommendation continued for thoracic MRI evaluation.

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

The requested thoracic spine MRI is medically necessary based on review of this medical record. This is a gentleman who had a significant xx/xx/xx injury, part of which was multiple

thoracic compression fractures and spinous fractures. The patient continues to have back and radicular leg complaints and his physician wants to determine whether or not he has developed any spinal stenosis, collapse of the fractures, nonunions or other abnormality which might correlate with his complaints. While Official Disability Guidelines discuss MRI imaging of thoracic spine in patients who have neurologic deficit, this is somewhat of an unusual patient in that he has had multiple thoracic fractures, which need to be followed up with diagnostic testing.

The requested thoracic spine MRI is medically necessary testing to determine whether or not the patient has ongoing thoracic pathology and in light of his ongoing back and leg complaints.

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates; Low Back- MRI

Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation)

Degenerative changes in the thoracic spine on MRI were observed in approximately half of the subjects with no symptoms in this study.

There is support for MRI, depending on symptoms and signs, to rule out serious pathology such as tumor, infection, fracture and cauda equina syndrome

Indications for imaging -- Magnetic resonance imaging

- Thoracic spine trauma: with neurological deficit
- Lumbar spine trauma: trauma, neurological deficit
- Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit)
- Uncomplicated low back pain, suspicion of cancer, infection, other "red flags"
- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. (For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.) (Andersson, 2000)
- Uncomplicated low back pain, prior lumbar surgery
- Uncomplicated low back pain, cauda equina syndrome
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, painful
- Myelopathy, sudden onset
- Myelopathy, stepwise progressive
- Myelopathy, slowly progressive
- Myelopathy, infectious disease patient
- Myelopathy, oncology patient

**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

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)