



Specialty Independent Review Organization
Notice of Independent Review Decision

DATE OF REVIEW: 4/22/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a cervical MRI (72141).

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 Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

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 prospective medical necessity of a cervical MRI (72141).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Neurosurgical Consultants and Healthcare WC

These records consist of the following (duplicate records are only listed from one source):
Records reviewed from Neurosurgical Consultants: MD Medical Conference Note – 3/23/11, Follow-up Notes – 8/26/09-2/21/11, and History, Physical, and Neurological Exam Report – 9/12/07.

Records reviewed from Healthcare WC: Denial Letters – 3/4/11 & 3/24/11; MD Office Note – 3/10/11, Pre-auth Request – undated; MD CT Cervical Spine report – 11/28/07; MD NCS/EMG report – 10/29/07; MD Peer Review Report – 2/2/09; DWC69 – 11/19/08; MD RME report – 12/1/08; and DWC73 – 11/19/08

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

PATIENT CLINICAL HISTORY [SUMMARY]:

Dr. notes were reviewed, including from 2/21/11 and 3/23/11 (a medical conference note only). The xx year old claimant was noted to be status post ACDF (in 11/07) at C6-7, for a large HNP and cord compression. (The prior visit had been on 8/26/09.) There was increased neck, shoulder and arm pain (with paresthesias) since approximately 1/15/11, by history. Reflexes were 1+/reduced symmetrically. Motor power is 5/5. Non-operative treatment was felt appropriate prior to a post-op. MRI. Denial letters noted the lack of ODG indications for a

cervical MRI, including the lack of neurologic issues. A 12/1/08 (1 year post-op) RME denoted that the operative procedure “..does not appear to have significantly changed the claimant’s symptoms”, and, a symmetrical absence of upper extremity reflexes.

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

There has not been follow-up documentation of the claimant’s response to the MedrolDose pack prescribed on 2/21/11. In addition, the overall neurological findings have been bilaterally symmetrical and not-documented to have been rapidly progressive. Plain cervical x-rays have not been provided either. Therefore, as per the applicable ODG criteria noted below, the cervical MRI proposed is not currently medically necessary.

ODG-Cervical Spine - 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
- Upper back/thoracic spine trauma with neurological

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)