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Notice of Independent Review Decision

DATE OF REVIEW: May 20, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI of the Cervical Spine without contrast and x-ray of the Cervical Spine. CPT Codes: 72141 and 72040.

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

WHO REVIEWED THE DECISION:

AMERICAN BOARD OF NEUROLOGICAL SURGERY

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

PATIENT CLINICAL HISTORY:

The description of service in dispute is an MRI of the cervical spine without contrast and x-ray of the cervical spine (CPT Codes: 72141 and 72040).

The description of the qualifications for each physician or other health care provider who reviewed the decision is a board certified neurosurgeon with additional training in pediatric neurosurgery.

The review outcome for an MRI of the cervical spine without contrast and x-ray of the cervical spine (CPT Codes: 72141 ad 72040) decision is upheld.

The patient is a xx-year-old male with a date of injury of when a rock fell on him. He sustained a chest fracture at T12, as well as the facets, as well as an L1 anterior chip fracture. The patient also sustained a jaw fracture.

The patient underwent a T10 to L2 fusion on August 26, 2010.

The patient did undergo an MRI of the cervical spine on August 25, 2010, that revealed annular bulges at C5-6 and C6-7, but with no significant stenosis.

The patient underwent physical therapy after his thoracolumbar fusion.

Eight months postoperatively, the patient complains of a stiff neck with difficulty turning his neck and pain into his left shoulder. His neurological examination on April 20, 2011, reveals

decreased sensation in the medial aspect of the right arm and decreased sensation in the lateral aspect of the left arm.

The request is for an MRI of the cervical spine, as well as an x-ray of the cervical spine.

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

The MRI of the cervical spine is not medically necessary. According to the ODG Neck and Upper Back Chapter, an MRI of the cervical spine is indicated when there is chronic neck pain after three months of conservative treatment with neurologic signs or symptoms present.

Firstly, this patient already had an MRI of the cervical spine immediately after his injury. Secondly, there is no evidence that the patient had any conservative therapy directed toward his neck. The patient has evidence of numbness; but, otherwise, there is no objective evidence of any neurologic compromise. Therefore, at this time, an MRI of the cervical spine is not warranted. The x-ray of the cervical spine is also not medically necessary.

According to the ODG Neck and Upper Back Chapter, this should be performed after cervical spine trauma or chronic neck pain after three months of conservative therapy. Again, there is no evidence that this patient has had any conservative therapy for his neck. There is not a complaint of neck pain until very recently since the time of his injury. The patient does not appear to have gotten any treatment towards his neck symptoms.

References are 2011 Official Disability Guidelines, 16th Edition, Neck and Upper Back Chapter, indication for imaging, magnetic resonance imaging, and x-rays of the cervical spine.

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)