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Notice of Independent Review Decision

DATE OF REVIEW: 10-16-2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a repeat cervical MRI with and without contrast (72156).

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 Anesthesiology. This 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 the repeat cervical MRI with and without contrast (72156).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: and MD.

These records consist of the following:

MDR paperwork
Pre-authorization request, appeal, and IRO from MD

Records from MD 8-6-2007, 8-23-2011, 9-28-2011
Atlas MRI 8-30-2007 report
Corvel preauthorization determination 8-29-2011, 9-14-2011
MD report 9-12-2011

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. The cause of injury was a lifting and twisting motion. A cervical MRI was performed on 08/30/07 which showed status post anterior fusion at C5-C7 and small spondylotic ridges at C3-C4 and C4-C5, no significant cord compression, mild bony foraminal encroachment at C4-C5 secondary to degenerative changes of uncovertebral joints. Unspecified x-rays were done but no results were provided as well as the radiologist's report.

Patient received the following treatments for this condition:

Surgery: ACDF to C6-C7 on 02/17/2005 and ACDF C5-C6 on 05/06/06

Injections: left C5-C6 and C6-C7 RFTCs on 04/2007, with 60% improvement; left RFTC on 2008 or 2009, levels not stated with 75% pain relief; three CESIs in 2004, without any relief,

Physical therapy

Pain medications – Effexor and Neurontin

Physical examination findings on 08/25/11 showed sensory deficit at the left C7 dermatomal distribution, intact deep tendon reflexes, weakness of the left biceps and positive bilateral Spurling's test. The reason for referral is medical necessity of an appeal for a repeat cervical MRI with and without contrast.

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

Recommend denial of the requested service. The request for an appeal for a repeat cervical MRI with and without contrast is not recommended as medically necessary. As per the latest medical report dated 08/23/11, the patient presented for a follow-up visit for medication evaluation. Her pain levels were graded at 5/10. She is noted to be improved in function in daily activities and her need for medication use was reduced. She was able to complete her activities of daily living without assistance. Physical examination showed sensory deficit at the left C7 dermatomal distribution, intact deep tendon reflexes, weakness of the left biceps and positive Spurling's test. Another medical report provided was dated 08/06/07 which did not document a comprehensive neurological evaluation of the patient. Although the patient presents with chronic pain and some neurological signs, the current subjective and objective findings do not suggest worsening or progression of the patient's condition in order to warrant repeat specialized imaging studies such as an MRI. There are no new neurological findings that would support a repeat MRI.

Criteria Used:

Official Disability Guidelines- Treatment for Worker's Compensation, Online Edition
Chapter: Neck and Upper Back (Acute and Chronic)

Magnetic Resonance Imaging (MRI)

Not recommended except for indications list below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurological findings, do not need imaging. Patients who do not fall into this category should have a three-view cervical radiographic series followed by computed tomography (CT). In determining whether or not the patient has ligamentous instability. 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). (Anderson, 2000) (ACR, 2002) See also ACR Appropriateness Criteria™. MRI imaging studies are valuable when physiologic evidence indicates tumor, infection and fracture, or for clarification of anatomy prior to surgery. (Bigos, 1999) (Bey, 1998) (Volle, 2001) (Singh, 2001) (Colorado, 2001) For the evaluation of the patient with chronic neck pain, plain radiographs (3-view: anteroposterior, lateral, open mouth) should be the initial study performed. Patients with normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging. If there is a contraindication to the magnetic resonance examination such as a cardiac pacemaker or severe claustrophobia, computed tomography myelography, preferably using spiral technology and multiplanar reconstruction is recommended. (Daffner, 2000) (Bono, 2007)

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)