

# CASEREVIEW

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Notice of Independent Review Decision

**DATE OF REVIEW:** September 8, 2011

**IRO CASE #:**

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

Repeat MRI Cervical Spine with Complete X-rays of Cervical Spine With Bending Views.

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

This physician is a Board Certified Orthopedic Surgeon with over 40 years of experience.

**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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1/13/04: M.D. performed a cervical medial branch block at right C2, C3, C4, C5 and C6.

8/17/06: MRI of the Cervical Spine was performed. Impression: Mild left foraminal narrowing at the C6-7 level due to some spurring. Postoperative changes with fusion but no significant narrowing at the upper levels.

11/7/06: M.D. evaluated the claimant.

2/21/07: M.D. evaluated the claimant.

12/8/10: M.D. performed a peer review on the claimant.

4/2/11: M.D. performed a peer review on the claimant.

8/2/11: M.D. evaluated the claimant. The claimant's last Cervical MRI was performed in 2009. PE: Neck reduced lordotic curvature. Decreased ROM in all directions. Muscle spasms and trigger points present. Occipital nerve root focally tender and concordant for headache. Motor Testing all groups were 5/5.

8/10/11: M.D. performed an UR on the claimant.

8/26/11: M.D. performed an UR on the claimant. Rationale for Denial: "MRI was to evaluate the parenthesis and weakness. However, there was no abnormal neurologic findings on physical therapy."

#### **PATIENT CLINICAL HISTORY:**

The claimant is a female with a history of cervical spine surgery performed in November 1999. Height = 54 inches and Weight = 180 lbs.

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

The previous decisions are upheld. There is no documentation of significant changes in the claimant's symptoms suggestive of significant pathology. Per the physical exam on 8/2/11, the claimant's exhibited normal bulk and tone with no muscle weakness. Per the ODG the claimant does not meet the criteria for a repeat MRI of the cervical spine.

#### **ODG:**

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 neurologic 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, magnetic resonance imaging (MRI) is the procedure of choice, but MRI should be reserved for patients who have clear-cut neurologic findings and those suspected

of 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](#)<sup>TM</sup>. MRI imaging studies are valuable when physiologic evidence indicates tissue insult or nerve impairment or potentially serious conditions are suspected like tumor, infection, and fracture, or for clarification of anatomy prior to surgery. MRI is the test of choice for patients who have had prior back 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](#))

**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 deficit

**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)