



Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 11/23/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The item in dispute is the prospective medical necessity of a magnetic resonance (EG, Proton) imaging, spinal canal and contents, cervical; without contrast material.

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.

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 prospective medical necessity of a magnetic resonance (EG, Proton) imaging, spinal canal and contents, cervical; without contrast material.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed:

LHL009 – 11/1/12

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Denial Letters – 10/22/12 & 10/26/12

Reconsideration Request Acknowledgement Letter – 10/24/12

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Medical Review Reports – 10/19/12, 10/26/12, 11/6/12

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Pre-authorization Request – 10/17/12

Office Note – 10/15/12, 10/19/12

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Office Notes – 9/17/12, 9/18/12, 9/19/12

Emergency Physician Record – 9/17/12

CT Scan Report – 9/17/12, 9/18/12

X-ray Report – 9/17/12

Telemetry Report – 9/17/12

Discharge Cumulative Report – 9/20/12

Records reviewed were all duplicates from above.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

A xx/xx/xx dated “neurosurgery admission note” revealed that the employee was “apparently struck by pipe.” Diagnoses included that of a cerebral concussion-contusion and cervical strain along with intracranial hemorrhage and post-concussion syndrome.” The CT scan of the brain dated 9/18/12 was compared to a study from the day before demonstrating a persistent hematoma in the left frontal lobe and a nearly resolved subarachnoid hemorrhage. Records from the treating provider were reviewed. These records document the employee was injured two months ago. A cervical CT scan dated 9/17/12 was noted to reveal “no evidence of acute traumatic injury of the cervical spine. Most recently, the claimant was evaluated on 10/15/12. There were subjective complaints of neck pain, recurrent headaches and post-concussion syndrome/”memory disturbance.” There were “depressive-type symptoms.” Exam findings were only documented to reveal tenderness at the level of the cervical spine. “Nothing focal was identified.” There was a consideration for an MRI as of 10/19/12. It was not denoted as to whether the MRI would be for the brain or the cervical spine. This was in order to evaluate for possible subdural hematoma or aneurysm. Denial letters indicated that there were no abnormal findings clinically or radiographically that supported an indication for a cervical MRI scan. There was no evidence of cervical x-rays, cervical radiculopathy and/or conservative treatment.

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

Applicable clinical guidelines support an MRI of the cervical spine in cases in which there is greater than three months of conservative treatment with residual-chronic neck pain, especially when neurologic symptoms or signs are present. In addition, such an MRI would be considered reasonable and medically necessary in a case in which there is significant probable radiculopathy. Chronic neck pain

with a suspected ligamentous injury is also an indication for an MRI scan. In this case, the only clinical abnormalities were neck pain and tenderness. There is no evidence of a suspicion of clinical instability. There was no evidence of subjective or objective findings compatible with suspected radiculopathy. There was no evidence of any abnormal findings on a CT scan of the cervical spine. Evidence of conservative treatment in order to attempt to resolve the clinical condition has not been documented. Therefore, applicable clinical guidelines do not support the requested MRI scan of the cervical spine at this time. The requested service is not medically necessary.

Reference: ODG Neck and Upper Back

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)**