

SENT VIA EMAIL OR FAX ON  
Dec/29/2011

## True Resolutions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**  
Dec/27/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Cervical MRI including 72141

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

**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**

OD Guidelines  
Utilization review 11/14/11  
Utilization review 12/12/11  
Pre-cert request 11/10/11  
Office visit notes Dr. 06/17/09 through 11/08/11  
Designated doctor evaluation Dr. 11/04/09  
Office notes Dr. 11/18/09 through 05/08/11  
Office notes Dr. etc.  
Letter 08/04/11 requesting referral from primary treating doctor  
First report of injury or illness  
X-rays lumbar spine 11/29/10  
MRI lumbar spine 11/29/10  
MRI cervical spine 08/25/09

**PATIENT CLINICAL HISTORY SUMMARY**

The injured worker is a female who was injured on xx/xx/xx when she twisted/turned after placing checks in mailbox and felt pain in upper/lower back. Claimant underwent designated doctor evaluation on 11/04/09 and was determined to have reached maximum medical improvement as of that date with 0% impairment rating. Claimant was seen by Dr. on 08/30/11. He noted he previously saw the injured worker in xx/xx and diagnosed with cervical and lumbar strain. She has been lost to follow up. She reportedly has gotten care via her PCP via private health insurance. She complains of pain in the neck and back radiating to the lower legs. She denies foot drop and incontinence. MRI of the lumbar spine dated 11/29/10 revealed mild degenerative changes from L3-4 to L5-S1 with no definite central canal stenosis seen. There was moderate bilateral neural foraminal narrowing secondary to hypertrophic facet changes from L3-4 to L5-S1. Examination revealed mild to moderate paraspinal cervical and lumbar spine tenderness, spasm. Deep tendon reflexes were intact. There was no foot drop. The injured worker was prescribed a trial of physical therapy to improve range of motion, endurance and pain control. The injured worker was seen in follow up on 11/08/11 and still reports neck, back pain radiating down right upper extremity, lower extremity. She is somewhat better participating in physical therapy. On examination there was normal gait, moderate paraspinal cervical and lumbar tenderness, spasm. Neuro exam was non-focal. It was noted that MRI is greater than two years old and repeat MRI of the lumbar cervical spine was recommended.

A pre-authorization request for MRI of the cervical spine was reviewed on 11/14/11 at which time it was determined the history and documentation do not objectively support the request for MRI of the cervical spine. There was no current clinical information that supported the request there was no evidence of focal neurologic impairment. Medical necessity of MRI has not been clearly demonstrated.

An appeal request for MRI of the cervical spine was reviewed on 12/12/11 and the request was non-certified as medically necessary. It was noted ODG recommends cervical MRI for chronic neck pain after 3 months of conservative treatment, radiographs normal, neurologic signs or symptoms present; neck pain with radiculopathy and severe progressive neurologic deficit; chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present; chronic neck pain, radiographs show old trauma, neurologic symptoms or signs present; chronic neck pain, radiographs show bone or disc margin obstruction; suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and / or CT "normal"; cervical spine trauma: equivocal or positive plain films with neurologic deficit. Records did not specify any cervical spine MRI indications listed above. The injured employee had symptoms of radiating pain, but did not have any objective evidence of severe or progressive neurologic deficits. There was no documentation of any objective evidence of abnormal neurologic findings. No cervical x-rays were specified in records provided. MRI of cervical and lumbar spine was performed two years ago, but the reports were not available for review. EMG/NCV studies of bilateral upper extremities were noted to show signs of radiculopathy were not documented. Based on the clinical information provided, and using evidence based peer review guidelines, medical necessity of cervical MRI is not established.

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

The proposed cervical MRI including 72141 is not supported as medically necessary by the clinical data submitted for review. The injured employee sustained a twisting injury on xx/xx/xx. She complained of neck and back pain. MRI of cervical spine on 08/25/09 revealed a large disc osteophyte complex at C5-6 with moderate central stenosis and moderate to severe foraminal stenosis. The injured employee apparently was treated by primary care physician until she returned to see Dr. on 08/30/11. The injured employee had subjective complaints of neck and back pain radiating to lower extremities, but there is no objective findings of motor, sensory or reflex changes. Per ODG guidelines, repeat MRI of cervical spine is not routinely recommended, and should be reserved for patients with significant change in symptoms or progressive neurologic deficit. As noted on previous review, the injured employee does not meet any criteria as specified in Official Disability Guidelines Neck

Chapter for cervical MRI. As such, the previous denials were correctly determined, and should be upheld on IRO.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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)