

**Notice of Independent Review Decision**

**DATE OF REVIEW: 06/25/2012**

**AMENDMENT DATE: 06/28/2012**

**IRO CASE #:**

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

*MRI of the cervical spine w/wo*

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

This case was reviewed by a Physician licensed in Texas since 2004 who holds a certification by the American Board of Physical Medicine and Rehabilitation.

**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**

<b>Type of Document Received</b>	<b>Date(s) of Record</b>
A followup office visit from, MD	10/15/2009
A followup office visit from, MD	11/30/2009
A followup office visit from, MD	02/22/2010
A followup office visit from, MD	05/17/2010
A followup office visit from, MD	05/24/2010
A followup office visit from, MD	08/09/2010
A followup office visit from, MD	11/04/2010
A followup office visit from, MD	01/18/2011
A followup office visit from, MD	03/04/2011
A DWC 73 from, MD	06/03/2011
A followup office visit from, MD	06/03/2011
A followup office visit from, MD	08/26/2011
A DWC 73 from, MD	12/01/2011
A followup office visit from, MD	12/01/2011
A followup office visit from, MD	01/20/2012



**MEDICAL**  
OF TEXAS ASO, L.L.C.

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A followup office visit from, MD	03/02/2012
A DWC 73 from, MD	03/02/2012
An EMG/NCV of upper extremities by, MD	03/21/2012
A DWC 73 from, MD	03/21/2012
A preauthorization request denial from Corvel	04/12/2012
A report from, MD	04/10/2012
A followup office visit from, MD	04/27/2012
A DWC 73 from, MD	04/27/2012
A preauthorization request denial from Corvel	05/07/2012
A report from, MD	05/07/2012
A request for a review by an IRO for the denied service of "MRI of the cervical spine w/wo"	05/18/2012

**EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

This is a female who sustained work-related injured to her neck on xx/xx/xx. She reported pain to her neck radiating down her right arm and was treated with conservative care including NSAIDs and opioid medications and trigger point injections. She subsequently underwent cervical fusion in 2001. Postoperatively, she continued to complain of increased pain symptoms. She is currently being treated by Dr. who recommended MRI of the cervical spine which is denied.

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

The patient does appear to have experienced an increase in overall neck and right arm pain that is activity related and noted to have been treated successfully with trigger point injections in the past. EMG done on 3/21/12 was suggestive of C8 nerve root irritation that is known to be a chronic condition based on provided documentation. On exam, the patient deficits include decreased neck range of motion, posterior right shoulder trigger points, and sensory deficits in the right C7-8 distribution. There was not reported significant right upper extremity motor weakness or muscle wasting, or a progressive deterioration of function suggestive of a worsening condition. On 8/26/11, this issue appeared to arise when patient reported returning to school where she was required to lift two disabled children in her class. This, along with reported increased stress levels, appear to have a strong correlation to the reported worsening on symptoms.

Based on ODG guidelines, MRI would be useful in this case as the patient has cervical related neurologic deficits. She also meets criteria of chronic neck pain after 3 months conservative treatment and neck pain with radiculopathy. However, the



worsening symptoms based on the history provided suggest that the worsening of symptoms is more likely myofascial related with associated radiculitis secondary to increased stress levels and lifting of two disabled students at work. In this case, the treatment would more likely be focused trigger point injections, physical therapy, and other adjunct treatments as appropriate to treat the myofascial related symptoms. It appears less likely that significant worsening of cervical related pathology has occurred.

Of note, the patient is status post two neck surgeries, at least one of which was a fusion. If instrumentation is in place, it is possible that artifact will occur rendering the study useless. In this case, CT myelogram would be the study of choice. Also, MRI if done would not be expected to require contrast as there is not clear evidence suggesting concern of cervical tumor or infection.

#### **ODG Indication for 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 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

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**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)