The DYLL REVIEW
We take the worry out of Peer Reviews
25 Highland Park Village #100-177 Dallas TX 75205
Phone: 888-950-4333 Fax: 888-9504-4443

Notice of Independent Review Decision

DATE OF REVIEW: 05/28/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical Necessity of MRI of Cervical Spine

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

The physician performing this review is Board Certified, American Board of Orthopedic Surgery. He has been in practice since 1998 and is licensed in Texas, Oklahoma, Minnesota and South Dakota.

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.

Upon independent review, I find the previous adverse determination should be overturned.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records Received: 15 page fax 05/09/12 Texas Department of Insurance IRO request, 16 pages of documents received via fax on 05/10/12 URA response to disputed services including administrative and medical, 15 pages of documents received via fax on 05/09/12 Provider response to disputed services including

administrative and medical. Dates of documents range from xx/xx/xx(DOI) to xx/xx/xx

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male with neck and arm pain following an injury suffered at work on xx/xx/xx. He was reportedly standing unloading a truck when he was struck from behind on the left side, which caused him to fall backwards, and he landed onto his left side. Since that time, he has had pain complaints with neck pain and periscapular pain that he has rated from a 6 to an 8 on a 0 to 10 scale. He has had chiropractic care and other conservative measures, including medications and physical therapy.

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

In my opinion, documentation clearly indicates the presence of cervical radiculopathy, as evidenced by findings of diminished sensation in a dermatomal pattern in the left arm as well as diminished strength of the left triceps muscle.

Additionally, there is evidence on CT scan indicating the potential for disk protrusion at the C5-6 level and additionally a sclerotic lesion at the C2 vertebral body, which is recommended for further evaluation. CT scan without contrast is of limited value in determining cervical radicular pathology. For this reason, it is felt the MRI would give additional information and again, in my opinion, should be allowed.

This patient suffered a work injury for which he suffers with neck pain and pain in the periscapular region. Physical examination findings are consistent with cervical radiculopathy. As such, based on the *ODG* guidelines mentioned below, it is my recommendation that the requested procedure of MRI of the cervical spine be approved.

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 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)

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See also ACR Appropriateness Criteria™. 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)