

Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 29, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
MRI for the cervical spine

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

This case was reviewed by a chiropractor licensed and currently practicing in the state of Texas.

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 decision is upheld for the denial of cervical MRI.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Type of Document Received	Date(s) of Record
Request for review by IRO for the denied service(s) of cervical MRI	02/08/2012
A letter from M.D from HDI	01/30/2012
A letter from M.D from HDI	02/07/2012
Individual Treatment Plan	09/01/2009 to 12/01/2009
FCE from Balance	08/25/2009

Designated Doctor report by, MD	07/01/2009
A letter from Disability Evaluating Center	08/07/2009
Appeal Letter of Adverse Determination	12/14/2011
A report from MD	11/21/2011
A report from Dr.	11/29/2011
A peer review by MD	07/07/2011
A DWC form 73 by DC	12/21/2011
A peer review by MD	08/11/2010
A DWC form 73 by DC	03/25/2010
A DWC form 73 by DC	02/10/2010
A DWC form 73 by DC	01/05/2010
A DWC form 73 by DC	11/04/2009
A DWC form 73 by DC	07/08/2009
A DWC form 73 by DC	07/01/2009
A DWC form 73 by DC	04/02/2009
A letter to dr. MD by RN	06/18/2009
An initial Mental Health and Pair Evaluation at Balance	04/24/2009
An FCE at Balance	09/23/2003
A letter from DO	04/07/2006
A letter from M.D.	07/30/2007

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This is a female who sustained injury on xx/xx/xx when she got caught under a desk and reported pain to her neck and right arm. Subsequently, she had MRI done that showed disc protrusions at multiple levels and had EMG done that showed C6 radiculopathy. She was treated by physical therapy, chiropractic treatment, medications and also underwent ESI which have been helpful but still complains of right sided neck pain down to her shoulders for which an MRI has been recommended by her doctor, however it was denied.

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

Based on the ODG, the MRI of the cervical spine is not recommended. Ms. had a MRI performed in 2003 and the physicians are now requesting a repeat MRI. The ODG states that the repeat MRI should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Documentation does not support this, therefore the prior decision is upheld.

ODG Current for MRI of the cervical spine:

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™. 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:



**MEDICAL
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- 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)