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Notice of Independent Review Decision

DATE OF REVIEW: 3/1/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the retrospective medical necessity of MRI neck spinal canal w/o dye 1 unit; DOS: 9/19/11; Modifier Rt MRI joint upper extremity without contrast 1 unit; DOS 9/19/11.

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. The reviewer has been practicing for greater than 10 years.

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 disagrees with the previous adverse determination regarding the MRI neck spinal canal w/o dye 1 unit; DOS: 9/19/11; Modifier Rt MRI joint upper extremity without contrast 1 unit; DOS 9/19/11.

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 from Preferred Open MRI: 10/17/11 EOB, various HICFA 1500 forms, 9/19/11 cervical MRI report, undated script for preferred open MRI, 8/26/11 to 1/16/12 SOAP notes from unknown party, 7/14/11 right shoulder and cervical radiographic reports, 8/2/11 handwritten initial consult notes exam form and palpatory exam report, 12/30/11 denial EOB (x2), 1/13/12

electrodiagnostic report, 9/19/11 shoulder MRI report, 8/25/11 x-ray report, and 7/14/11 ED notes from (physician, nursing).

2/3/12 letter by 2/3/12 IRO summary report, 7/27/11 form 1, 9/16/11 to 9/21/11 PLN 11 forms, 7/26/11 workers statement, letter by 7/26/11 record release authorization, 7/26/11 WC request for medical care form, 7/26/11 bona fide job offer, 7/14/11 discharge instructions from, 8/2/11 to 8/3/11 work notes, 8/2/11 to 1/26/12 handwritten SOAP notes, various DWC 73 forms, 8/3/11 script, 8/4/11 PPE report, 8/16/11 to 8/29/11 PT and aquatic therapy worksheets, various MD fee slips, FCE report by, 9/6/11 report by /20/11 script, 10/21/11 RME report by 12/15/11 RME by 1/4/11 to 1/13/12 notes by 10/12/11 denial letter, 10/17/11 denial letter, and 12/28/11 denial letter.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the records, the patient has had chronic neck and right shoulder pain, along with tenderness since the date of injury on xx/xx/xx. This was attributed to repetitive motion keyboard-associated activities while working. Decreased cervical sensation was noted in a dermatomal pattern. There was a positive shoulder apprehension sign and decreased motion. The 9/19/11 dated cervical MRI revealed disk bulges and degenerative changes and/or bulging discs. The shoulder MRI from the same date revealed tendinopathy/partial cuff tear, AC joint arthrosis and bursal proliferation. Treatments included medications and chiropractic. Denial letters discussed a non-causally related injury mechanism and normal neurological examination. Appeal letters discussed a keyboard being non-ergonomically placed and repetitive motion activities.

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

Applicable guidelines do support medical necessity of the cervical and shoulder MRI. The records do denote that there was numbness ("neurologic symptoms" as per ODG) in the clinical distribution of multiple cervical nerve roots. That fact, along with persistent neck pain supports a diagnosis of cervical radiculopathy that was persistent despite treatment for months. The shoulder pain, tenderness and positive apprehension sign all supported a diagnosis of either (labral tear and/or rotator cuff tear/impingement, as per ODG), also resistant to reasonable comprehensive treatment for months. Therefore both MRI were positively indicated as ODG-associated criteria referenced below were present. Pursuant to this fact, the requested service is found to be medically necessary at this time.

Reference: ODG Cervical and Shoulder MRI

Shoulder Indications for imaging -- Magnetic resonance imaging (MRI):

- Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs
- Subacute shoulder pain, suspect instability/labral tear

- Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008)

Cervical Spine: 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)