

Notice of Independent Review Decision

DATE OF REVIEW: 05/02/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI Cervical Spine without contrast

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, the reviewer finds the previous adverse determinations should be upheld.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records Received: 13 page fax 04/23/12 Texas Department of Insurance IRO request, 50 pages of documents received via fax on 04/23/12 URA response to disputed services including administrative and medical. Dates of documents range from 05/25/10 (DOI) to 04/23/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female injured in a motor vehicle accident xx/xx/xx with a diagnosis of cervical disk displacement. There have been plain x-rays, MRI, and EMG studies performed. The patient shows no evidence of radiculopathy on the EMG. The patient's clinical symptoms include neck pain and shoulder pain with weakness and numbness and tingling into the arms.

Medical records show no significant change in the symptomatic picture.

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

With the ODG guidelines below and in the absence of clinical impression changes in the examination findings, the requested procedure for a cervical MRI is not certified.

From the medical records available for review, the patient has continued symptoms, which have not appreciably changed since the previous MRI of the cervical spine on 06/24/10. Additionally, an electrodiagnostic study performed more recently, 09/13/11, revealed no evidence of radiculopathy. As such, the request for the procedure is not certified.

This determination was based purely on the medical records made available for my review. At no point have I had the opportunity to meet and/or examine this patient in person. Nor have I had the opportunity to review the radiographic images referenced in the clinical records. The determination was based on these medical records and descriptions of the imaging studies.

72141 *Mri neck spine w/o dye*

Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material

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](#)TM. 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:

- 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)