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Notice of Independent Review Decision

**Date notice sent to all parties: 10/9/13**

**IRO CASE #:**

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

MRI cervical without contrast 72141

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

Texas Licensed Board Certified Orthopedic Surgeon

**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 medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

A medical record indicates that the patient was seen on xxxxx by a healthcare provider with complaints of neck pain said to be the result of a fall. There was no description of cervical radicular complaints. There was no description of abnormal neurological findings. A report of a cervical MRI scan done on 12/6/12 with a clinical history of "neck pain radiating into the left upper extremity" describes a left paracentral disc herniation at the C5-6 level with "mild cord compression and severe impingement of the neural exit canal's bilaterally greater on the left side". A medical record indicates that the patient was seen on 12/20/12. with complaints of neck pain. It was noted, "the patient denies any radicular arm pain". There was no description of abnormal neurological findings. A medical record indicates that the patient was seen on 2/21/13 with apparent complaints of neck pain said to be 6 in severity on a scale of 10. There was no description of radicular complaints. A medical record indicates that the patient underwent a cervical epidural injection done on 4/18/13 with complaints of "neck pain radiating to upper extremities". A medical record indicates that the patient was seen by a healthcare provider on 5/23/13 with apparent complaints of neck and left arm pain. She was said to have decreased grip strength on the left and decreased sensation in that extremity. A medical record indicates that the patient was seen on 6/27/13. with "left-sided radicular pain". She was said to need "new MRI C spine for surgical planning".

The patient is aid to have injured her neck while working on xx/xx/xx. She had following this complaints of neck pain without any clinical documentation of radicular complaints. A report of a cervical MRI scan done on 12/6/12 with a clinical history of "neck pain radiating into the left upper extremity" describes a left paracentral disc herniation at the C5-6 level with "mild cord compression and severe impingement of the neural exit canal's bilaterally greater on the left side".

She was seen as late as 2/21/13 with complaints of neck pain and without documentation of radicular complaints. I have seen no clear description of abnormal neurological findings documented. She was described on 6/27/13 as having complaints of "left-sided radicular pain". She was said to need "new MRI C spine for surgical planning".

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

ODG has specific indications for cervical MRI scans. Under the MRI section of the neck the ODG states: "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology." It is reasonable that the presence of progressive neurological findings would be an appropriate indication for a repeat cervical MRI scan. This is not clearly documented in these records by the patient's treating physician. It has been stated that the patient requires a repeat cervical MRI scan for "surgical planning". I see no indication to repeat a cervical MRI scan.

**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)**