

# Becket Systems

An Independent Review Organization  
815-A Brazos St #499  
Austin, TX 78701  
Phone: (512) 553-0360  
Fax: (207) 470-1075  
Email: manager@becketystems.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** May/29/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** cervical spine MRI w/o contrast

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** D. O. Board Certified Neurological Surgery

**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 health care service in dispute.** It is the opinion of the reviewer that the request for a cervical spine MRI w/o contrast is not recommended as medically necessary

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

ODG - Official Disability Guidelines & Treatment Guidelines  
Clinical note dated 03/20/13  
Previous utilization reviews dated 04/08/13 & 04/19/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female who reported an injury regarding her cervical region. The clinical note dated xx/xx/xx details the patient complaining of cervical region pain with radiation of pain into both shoulders. The patient demonstrated limited range of motion of the cervical spine secondary to pain. The note does detail the patient utilizing Tylenol with some benefit. However, the note does detail the patient having currently received no conservative treatments. The note does detail the patient also utilizing Norco and Flexeril for ongoing pain relief. The patient stated the pain has affected her activities of daily living and she was having difficulty with washing dishes, mopping, and sweeping. The patient was noted to have previously undergone a C5-6 fusion in 1998 with a good response. However, 2 years prior the patient noted a return to pain. The note does detail the patient having undergone x-rays which confirmed the loss of disc height at C4-5 and C6-7 as well as a well healed fusion at C5-6. No evidence of any haloing of the hardware is noted. No instability was noted with flexion or extension views.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The documentation submitted for review elaborates the patient complaining of cervical region pain. Radiation of pain was noted into both shoulders. The Official Disability Guidelines recommend a MRI of the cervical region provided the patient meets specific criteria to include significant clinical findings indicating a radiculopathy component. No information was submitted regarding the patient's radiculopathy component noted by clinical exam. Additionally, it is unclear if the patient completed any additional conservative therapies. Given that no information was submitted

regarding the patient's significant clinical findings indicating a radiculopathy component and taking into account the lack of information regarding the patient's completion of all conservative measures, this request does not meet the necessary criteria for a MRI of the cervical spine. As such, it is the opinion of the reviewer that the request for a cervical spine MRI w/o contrast is not recommended as medically necessary.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

ACOEM-AMERICA 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)