

True Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Mar/05/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Thoracic MRI without contrast

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

Board Certified Neurosurgeon

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who has previously undergone a fusion at the C4-5 through C6-7 levels. The x-rays of the cervical spine dated xxxxx revealed no evidence of abnormal motion at the fused levels between flexion and extension. The clinical note dated 12/23/13 indicates the patient complaining of posterior neck pain as well as right sided trapezial region and interscapular pain. Numbness and tingling were noted on the right. Radiating pain was noted into the right trapezial area. The pain was noted to be intermittent in nature. The note does mention the patient's pain being well controlled with the use of MS Contin and Tizanidine. The patient also noted right sided occipital headaches with radiating pain into the right parietal area. Upon exam, tenderness was noted at the right trapezial and posterior cervical area with moderate spasms. Tenderness also was noted at the right suboccipital region. Reflexes were noted to be absent at the right triceps. The x-ray of the cervical spine dated 12/27/13 revealed a solid fusion at C4-5, C5-6, and C6-7. A Synthese plate was noted at C4-5 and C6-7. The clinical note dated 12/31/13 indicates the patient continuing with complaints of pain in the cervical region, the left shoulder, and both elbows. The patient also noted lumbar region pain radiating to the posterior aspect of both legs. The patient also reported a stabbing type pain in the thoracic spine. The patient rated his pain as 8-9/10 at that time. Pain was exacerbated with prolonged standing or walking. Numbness was noted in the left foot and the right arm. Weakness was also noted in both hands. The note does mention the patient having previously been utilizing a TENS unit as well as physical therapy with no significant benefit. The previous use of a spinal cord stimulator was noted to have

failed. The patient denied any chest pain. No abdominal pain was noted. Upon exam, 4/5 strength was noted throughout the upper extremities. The patient was noted to have an antalgic gait with a right sided limp as well as a forward flexed posture. The patient had been recommended for a thoracic MRI.

The utilization review dated 01/08/14 resulted in a denial for a thoracic MRI as no evidence of neurologic deficits directly related to the thoracic region were noted in the documentation. No information was submitted confirming the patient's recent completion of any conservative therapy.

The utilization review dated 02/05/14 resulted in a denial for a thoracic MRI as no progressive neurologic deficits were noted. No radicular pain was noted.

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

The documentation indicates the patient having complaints of cervical, thoracic, and lumbar region pain. A thoracic MRI would be indicated provided the patient is noted to have neurologic deficits. No information was submitted confirming the patient's neurologic deficits related to the thoracic spine. No thoracic spine trauma was noted in the documentation. As no information was submitted confirming the patient's spinal trauma to the thoracic region and taking into account that no neurologic deficits were noted in the documentation, this request is not indicated. As such, it is the opinion of this reviewer that the request for a thoracic MRI without 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:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES