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## Notice of Independent Review Decision

**DATE OF REVIEW:** 8/21/2014

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of Cervical MRI without contrast.

**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.

**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 agrees with the previous adverse determination regarding the medical necessity of Cervical MRI without contrast.

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant was noted to have been involved in a motor vehicle accident on the date of injury. Reportedly with reported groin and back injuries. The injuries were noted to have been compatible with that of an abdominal contusion and a lumbosacral strain. The claimant is noted to be status post spinal fusion at L5-S 1 in October 2010, with a solid fusion noted on a lumbar MRI from April 2014. Clinical notes from June 9, 2014 documented a normal

neurologic examination of the upper extremities including sensation, motor power and reflexes. X-rays were going to reveal spondylosis at multiple levels including listhesis. The cervical range of motion was noted to be painful but normal. The Spurling test was noted to be negative. The reconsideration request and details were noted. Prior clinical records were also reviewed. Denial letters reflected that there was a normal neurological evaluation documented clinically and the lack of MRI-associated nerve root compression. In addition there was noted to have been a lack of nonoperative treatment protocol tried and failed.

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

Applicable clinical guideline support a cervical MRI scan when there is evidence of prior trauma with neurologic signs or symptoms present. In this case, the findings did not evidence significant or progressive neurologic abnormalities. In addition; evidence of a recent and comprehensive nonoperative treatment protocol trial and failure has not been documented. Therefore the request cannot be considered medically reasonable or necessary as per guidelines referenced below.

**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)