

Health Decisions, Inc.

6601 CR 1022

Joshua, TX 76058

P 972-800-0641

F 888-349-9735

Notice of Independent Review Decision

April 13, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI with and without contrast of the Cervical spine

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

A Board Certified Anesthesiologist with experience in Pain Management

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an injury on xx/xx/xx from bending and stooping. She is status post right L5-S1 hemilaminectomy with disc excision in 2003 and 2 level spine fusion C5-7 with development of apseudoarthrosis and failed back syndrome.

05-12-08: Cervical Myelogram and CT Post Cervical Myelogram. Impression: No spinal canal stenosis or cord compression. Anterior and interbody fusion C5, C6 and C7 with intact metallic hardware. The C5-C6 intervertebral disc graft is well incorporated. The C6-C7 intervertebral disc graft in the process of incorporation with incomplete bony bridging. At C4-C5, left paracentral spondylotic disc protrusion resulting in left hemicord flattening and deformity of the ventral outlet of the left C5 nerve root sleeve. There is no underfilling of exiting nerve root sleeves or significant neural foraminal narrowing.

08-07-08: Nerve Conduction Report. Impression: Abnormal study consistent with bilateral median nerve entrapments at the wrist. Severe on the left and moderate on the right.

11-30-10: Cervical Spine CT Myelogram. Findings: The cervical lordosis is maintained. The vertebral body heights are preserved. C5-6 and C6-7 interbody fusions are seen. Lucency through the C6-7 interbody bone graft is suspicious for pseudarthrosis. The anterior stabilization plate and screws spanning C5 through C7 show no evidence for loosening or hardware failure. Ossification of the anterior longitudinal ligament at C3-4, C4-5 and C7-T1 are seen. C3-4: There is mild spondylosis and annular disc bulging making the spinal canal less normal. No foraminal stenosis is shown. C4-5: Moderate spondylosis and annular disc bulging are superimposed on left uncovertebral osteoarthritis. A left dorsolateral disc-osteophyte complex narrows the left lateral recess and impinges on the left C5 nerve root axilla. The left ventral surface of the spinal cord is also indented. The AP dimensions of the thecal sac measures 8 mm in the midline.

10-30-14: Clinical Encounter Summary. Patient reported pain was tolerable with current medication. Patient was able to function on the current medications and they allowed for activities of daily living. Pain scale with medication was a 3, without medication was an 8. On physical examination there were no changes since previous visit. Assessment: Neck pain, Low back pain and Cervical post-laminectomy syndrome. Plan: Baclofen 10 mg tablet, Lyrica 100 mg capsule, Hydrocodone 10 mg-acetaminophen 325 mg tablet, Methadone 10 mg tablet, and Effexor XR 150 mg capsule. Discussion Notes: Pt reported that recommended a CT and MRI of her neck to evaluate for possible lesions, therefore, he would order a CT and MRI of the neck.

11-24-14: Clinical Encounter Summary. Patient presented with chief complaint of shoulder pain, upper extremity pain, neuropathic pain, lower extremity pain and knee pain. On physical examination there was pain with range of motion, lateral rotation bilaterally. Spurling's Test was positive. Medications were refilled. Discussion Note: The patient reported ongoing neck pain that radiates into her right greater than left upper extremity with associating numbness, tingling and subjective weakness. Due to not being able to obtain medical records. has been unable to order the MRI and CT scan of the neck.

01-12-15: Clinical Encounter Summary. Patient presented with ongoing pain. She also reported facial numbness and numbness sensation on the roof of her mouth. No changes were reported on physical examination. Medications were refilled. It was noted they had received records. had recommended the patient for a cervical MRI with and without contrast to further evaluate her upper extremity symptoms and a CT scan to evaluate competency of the cervical fusion. would order the MRI and CT scan. It was also noted here SCS was reprogrammed.

02-06-15: URA. Rationale: Per ODG low back guidelines cited below, "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)." A detailed physical examination of the cervical spine was not specified in the records provided. The patient has had CT myelogram in 11/30/210 and

5/12/2008 that revealed a solid fusion. Patient does not have any severe or progressive neurological deficits that are specified in the records provided. Any significant changes in objective physical examination findings since the last study that would require a repeat imaging study were not specified in the records provided. The findings suggestive of or suspicious for tumor, infection, fracture, neurocompression, or other red flags were not specified in the records provided. A report of the X-rays of the cervical spine was not specified in the records provided. The details of PT or other types of therapy done since the date of injury were not specified in the records provided. Response to any prior conservative therapy for this injury was not specified in the records provided. Previous PT notes were not specified in the records provided. With this it is deemed that based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, the medical necessity of Repeat MRI w/wo cervical spine is not established for this patient.

02-24-15: URA. Rationale: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. There is no evidence provided of progression or worsening of symptoms or physical examination findings. There was no evidence of neurological deficit on physical examination.

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

The previous adverse determinations are upheld. Per ODG there should be significant change in symptoms and/or significant pathology in order to justify repeat MRI. Patient does not have any severe or progressive neurological deficits that are specified in the records provided. Any significant changes in objective physical examination findings since the last study that would require a repeat imaging study were not specified in the records provided. Therefore, this request for MRI with and without contrast of the Cervical spine is non-certified.

PER ODG:

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) See also ACR Appropriateness Criteria™ . 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
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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)**