

Notice of Independent Review Decision

September 23, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI cervical spine and MRI lumbar spine

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

Orthopedic Physician

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 male who sustained an injury on xx/xx/xx. The patient fell and struck the neck and lower back.

Computerized tomography (CT) scan of the head and cervical spine dated June 17, 2015, documented no acute intracranial abnormality and unremarkable cervical spine. X-rays of the lumbar spine on June 17, 2015, and July 13, 2015, documented minimal disc space narrowing at L4-L5, otherwise unremarkable. X-rays of the thoracic spine demonstrated spondylosis but no acute abnormality.

The patient was evaluated on June 23, 2015, and was diagnosed with neck pain. A prescription

was given for therapy. The rest of the report is largely illegible.

On July 8, 2015, ordered a magnetic resonance imaging (MRI) of the cervical spine and lumbar spine for complaints of neck pain and back pain, right upper extremity numbness and pain.

On July 12, 2015, a CT scan of the brain was obtained for dizziness. There was no acute intracranial process. Stable deep and periventricular white matter low attenuation changes suggested white matter disease or microangiopathic changes.

Per a utilization review dated July 16, 2015, the request for MRI of the cervical spine and MRI of the lumbar spine was denied with the following rationale: *“For the described medical situation, Official Disability Guidelines would not support this specific request to be one of medical necessity. At the present time, this reference would not support this request to be one of medical necessity as the submitted documentation does not indicate the presence of a specific neurological deficit on physical examination to support this specific request as one of medical necessity. As such, per criteria set forth by the above noted reference, medical necessity for this request is not currently established.”*

According to the office visit dated July 28, 2015, noted complaints of headaches, neck and back pain after the injury. The patient denied sphincter problems. The patient had not improved with expectant management. The patient was also having complaints of tingling and numbness in the upper and lower extremities. The review of systems was significant in the musculoskeletal and neurological system with the history of the present illness. The rest of the systems were negative. On physical examination, the patient was conscious, alert and oriented person, place and time. There was no evidence of cranial nerve deficits from II - XII. There was no Hoffman, no clonus and no Babinski. The patient was in no distress. There was a limited range of motion in the cervical spine and lumbar spine, with tenderness to palpation in the paraspinal muscles. Recent and remote memory was intact. Attention span, language, concentration and fund of knowledge were adequate. There was decreased sensation to soft touch in the upper and lower extremities. There were no focal motor or sensory deficits noted. The motor examination was 5/5 in both upper and lower extremities. Deep tendon reflexes were + 2 in the upper and lower extremities. There was no edema or swelling in the upper and lower extremities. The peripheral pulses were normal. There was no obvious deformity. The patient was well-developed and well nourished for the age. Treatment plan included magnetic resonance imaging of the cervical and lumbar spine for further recommendations.

Revision of the cervical spine x-rays reviewed on July 28, 2015, documented spondylitic changes at multiple levels.

On August 18, 2015, the appeal for MRI of the cervical spine and lumbar spine without contrast was non-authorized with the following rationale: *“1) Patient has neck and back pain. The patient has no focal motor, sensory or reflex changes on exam and has spondylitis changes on x-ray. The request does not meet evidence-based guidelines. There are no red flag conditions that indicate an MRI.*

Therefore, the request is not medically necessary or appropriate. 2) Again, there are no red flag indicators that warrant an MRI. As such, the request is not medically necessary or appropriate.”

On August 27, 2015, noted ongoing neck and back pain with radiation into the upper and lower extremities. Medication was not improving his symptoms or expectant management. The patient had stated the pain originally started on. The pain was better with medications and rest and was worse with standing and bending. The patient had pain management with in July 2015 with temporary improvement in his pain. He had physical therapy at Reaction in August 2015 with 20% improvement. The patient rated the level of pain at an 8 out of 10 with 10 being excruciating pain. The diagnoses were cervicalgia and lumbalgia. ordered MRI of the cervical and lumbar spine.

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

The request would be denied based on current clinical documentation as well as Official Disability Guidelines. The claimant is a old gentleman who sustained an injury dating. He had both neck and low back pain. There has been a request for cervical spine and lumbar spine MRI. Clinical documentation on separate reviews clearly shows evidence of no significant motor or sensory deficit. This is noted on the visit with on 07/20/15. In that physical examination note, there is subjective decrease sensation to soft touch in the upper and lower extremities, but no dermatomal pattern is recorded. He goes on to say that there was no focal or sensory deficits noted and that motor examination showed 5/5 strength in both upper and lower extremities. Deep tendon reflexes were also intact, +2 in nature of the upper and lower extremities. With that clinical information provided, there is no evidence to proceed with an MRI of the cervical low lumbar spine. The request does not meet evidence based guidelines and there are no red flag conditions that would indicate the utilization of an MRI. Either further documentation or peer to peer review would be beneficial; however, based on the notes provided, the request would be denied.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines (20th annual edition), 2015
Neck and Upper Back Chapter
Magnetic resonance imaging (MRI)

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

Official Disability Guidelines (20th annual edition), 2015

Low Back Chapter

Magnetic resonance imaging (MRI)

Indications for imaging -- Magnetic resonance imaging:

- Thoracic spine trauma: with neurological deficit
- Lumbar spine trauma: trauma, neurological deficit
- Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit)
- Uncomplicated low back pain, suspicion of cancer, infection, other "red flags"
- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit.
- Uncomplicated low back pain, prior lumbar surgery
- Uncomplicated low back pain, cauda equina syndrome
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, painful
- Myelopathy, sudden onset
- Myelopathy, stepwise progressive
- Myelopathy, slowly progressive
- Myelopathy, infectious disease patient
- Myelopathy, oncology patient
- Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation)