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September 2, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Cervical MRI without contrast
Cervical MRI without contrast

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Fellow American Academy of Physical Medicine and Rehabilitation

REVIEW OUTCOME:

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an industrial-related injury when he was rear-ended by another vehicle going about 70 mph.

On evaluated the patient for small bilateral skin contusions to the shins, one on each side, which he received from the motor vehicle accident (MVA). The pain was superficial and he felt mildly sore. Examination revealed bilateral dime-sized contusions to each shin. The pain was rated as 1/10. The diagnoses were MVA with injury to both shins. prescribed ibuprofen and recommended continuing full duty without restrictions.

On March 30, 2015, noted the patient had mild-to-moderate low back pain that was aggravated by bending, extension and sitting. Examination showed lumbar spine paraspinal muscle tenderness and mild pain with range of motion (ROM). There were mild contusions on the bilateral shins

anteriorly. The diagnoses were acute low back pain. The patient was provided Biofreeze samples and advised to continue ibuprofen and perform mild stretching and massage. He was released to full duty.

On April 1, 2015 saw the patient for continued low back pain with newly developed sciatica. The patient reported moderate pain in the lower back and gluteal area radiating to the left thigh. He was not compliant with ibuprofen, Biofreeze, warm/moist heat and mild stretching. On examination, the lumbar spine showed left-sided tenderness with pain radiating down the left side. The diagnoses were acute low back strain and acute sciatica. X-rays of the lumbar spine was ordered. The patient was recommended continuing current treatment plan.

On April 1, 2015, x-rays of the lumbar spine showed mild degenerative changes of the thoracolumbar junction. No acute fracture or significant disc space narrowing was noted.

On April 2, 2015, reviewed x-rays of the lumbar spine and recommended continuing current treatment plan without change. Flexeril and prednisone was added to the medical regimen. If his condition worsened in 10-14 days, he was then to be referred to pain management.

On April 17, 2015, noted the patient's back pain was stable at 6/10 with radiation to left thigh. The symptoms were aggravated by extension, flexion and twisting, and relieved by lying down. The patient was recommended continuing current treatment plan and was referred to an orthopedist.

From April 22, 2015, through April 29, 2015, the patient underwent chiropractic therapy at with modalities to include chiropractic manipulative therapy (CMT) to thoracic and lumbosacral region, hot/cold pack to upper neck and EMS to lower back.

On April 29, 2015, noted the symptoms were relieved by chiropractic therapy, however the pain returned in one to two days. The patient was recommended continuing current treatment plan and finishing chiropractic as scheduled.

On May 15, 2015, magnetic resonance imaging (MRI) of the lumbar spine showed central and right-sided disc protrusion at L5-S1 level with obliteration of epidural and impingement on the right S1 nerve root. There was no evidence of spinal stenosis, spondylosis or spondylolisthesis.

On July 8, 2015, , evaluated the patient for back pain and leg pain that started after an MVA. He had pain in the low back radiating down the bilateral legs. He stated the right leg was worse. The pain was worse at night and woke him up from his sleep. The pain was present when he coughed. His leg hurt if he walked too far more than three blocks. The pain was worse with sitting, walking, lying down, rising from the chair and with physical activity. The patient also had neck pain. He reported chiropractic care made it better and there was no change with physical therapy (PT). He was utilizing Ultracet, Celebrex and Medrol Dosepak. On examination, the neck was unremarkable. There was significant spinal tenderness in the paraspinal muscles. Bilateral straight leg raise (SLR)

was negative. There were negative Waddell signs, Spurling's and Lhermitte's sign. He had spinal motion with pain, but demonstrated good ROM with flexion, extension, side bending and rotation. X-ray of the lumbar spine showed significant disc space narrowing at L5-S1 reviewed the lumbar MRI and assessed low back pain secondary to lumbar disc disease L5-S1 with herniated disc pulposus and foraminal stenosis. The diagnoses were neck pain, low back pain and lumbar intervertebral disc without myelopathy. The patient was recommended PT 6-8 weeks consisting of strengthening, range-of-motion, core isometric exercises and modalities. An MRI of the cervical spine was ordered. The patient was to continue medications and was to consider epidural steroid injection (ESI) to the lumbar spine. A manual muscle strength examination of the lumbar spine revealed current pain rating at 8/10.

Per a utilization review dated July 20, 2015, the request for cervical MRI without contrast was denied with the following rationale: *"In my judgment, the clinical information provided does not establish the medical necessity of this request. This request is not supported within the current Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) Chapter regarding cervical MRI. In this case, the patient has had symptoms of chronic neck pain after at least three months of conservative treatment with normal cervical radiographs and neurologic signs present may be appropriate indications for a cervical MRI. The patient's date of injury was and I am unable to determine any plain films of the cervical spine were taken. There is mention of lumbar radiographs; however, no cervical radiographs and it is apparent that the patient has undergone conservative treatment in the three months since the date of injury. Due to lack of evaluation on plain cervical films, medical necessity of this request has not been established."*

Per a reconsideration review dated August 2, 2015, denied the appeal for a cervical MRI without contrast with the following rationale: *"In my judgment, the clinical information provided does not establish the medical necessity of this request. In this case, the medical records indicate completely normal physical examination of the cervical spine neurologically with negative Rhomboids, negative Lhermitte's, negative Hoffmann's, and negative Spurling's. There are no signs of reflux change, sensory change, or muscle weakness in a myotomal pattern. Therefore, the request is not medically necessary within the Official Disability Guidelines Neck and Upper Back Chapter regarding cervical MRI criteria."*

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

There is nothing in the records to support the need of a cervical MRI. The only mention was the "patient also had neck pain". This is clearly not an objective finding requiring an MRI and the physical was normal as there is nothing in the records indicating any type of neurologic issues. In addition, there is no mention of x-rays taken. or that plain radiographs were taken. ODG states: "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". None of these criteria have been met based on the medical records.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES