MEDRx

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DATE OF REVIEW: February 26, 2018

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Clinical spine MRI w/o contrast - 72141

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 disagrees with the previous adverse determination regarding the medical necessity of: Clinical spine MRI w/o contrast – 72141.

PATIENT CLINICAL HISTORY [SUMMARY]:
This claimant is a XXXX who sustained an XX on XXXX. The mechanism of injury was described as a XXXX. XXXX sustained a non-displaced intra-articular fracture at the base of the 5th metacarpal. Past medical history was positive for cervical fusion at C5/6 in XXXX for spinal stenosis and cord impingement. XXXX was diagnosed with a right shoulder supraspinatus tendon tear and underwent a right shoulder rotator cuff repair in XXXX. The XXXX pain management report documented clinical history and physical exam findings consistent with the diagnosis of complex regional pain syndrome (CRPS) type 1 of the right upper extremity. It was noted that the claimant was a potential candidate for spinal cord stimulation. A psychological evaluation was ordered. The XXXX psychological report indicated that the claimant did not present evidence of any psychological difficulties which would contraindicate XXXX having a spinal cord stimulator. Authorization was requested on XXXX for a cervical spine MRI for neck and arm pain, prior cervical surgery, and XXXX needed spinal cord stimulator. The XXXX adverse determination letter indicated that the request for cervical spine MRI was non-authorized as prior diagnostic imaging was not provided for review, substantial changes on examination to suggest progressive neurologic deficit were not documented, plain x-rays of the prior fusion were not provided, and timing of the prior fusion was not specified to support the medical necessity of repeat MRI. The XXXX pain management report indicated that the claimant was seen for follow-up of XXXX right upper extremity pain. XXXX complained of burning numbness. XXXX right upper extremity remained swollen, often cool to touch, with intermittent mottling or color changes. XXXX was status post two stellate ganglion blocks with 50% reduction in XXXX shoulder pain for

about one week and improvement in range of motion. XXXX had less difficulty raising XXXX arm above XXXX head and behind XXXX back. XXXX continued physical therapy. XXXX had a C5/6 fusion in XXXX and had no imaging of XXXX cervical spine since then. XXXX was an ideal candidate for spinal cord stimulation therapy. XXXX reported pain was 5/10 with medications, and 7/10 without. XXXX was not working. XXXX had tried NSAIDs, physical therapy, opiates, and neuropathic medications with partial to no relief. The diagnosis was documented as Type 1 CRPS, right upper extremity. It was noted that the claimant had failed to improve with conservative treatment and was an ideal candidate for spinal cord stimulation trial. A cervical MRI was needed before the trial as XXXX had a history of cervical spinal stenosis with a prior cervical fusion, to assess for any cervical stenosis prior to inserting the spinal cord stimulation leads. The treatment plan recommended cervical spinal cord stimulator trial and MRI of the cervical spine. The XXXX pain management chart note indicated that the claimant had persistent right hand pain from CRPS. XXXX had failed to respond to conservative treatments and XXXX right hand pain was worsening. XXXX had signs of allodynia, discoloration, swelling, increased temperature and weakness in the right hand. XXXX had responded well to stellate ganglion blocks which provided at least 60% pain relief. XXXX wanted to avoid medication for XXXX pain if at all possible. XXXX was an ideal candidate for spinal cord stimulator therapy. However, XXXX must have a cervical MRI before this. An MRI was medically indicated prior to placement of the spinal cord stimulator leads due to XXXX worsening hand pain and to assess the state of XXXX spinal canal. If XXXX had nerve or spinal cord compression, this must be determined prior to a spinal cord stimulator procedure as other treatment options would be indicated. An MRI was also critical to ensure that there was sufficient space to safely place epidural leads and was the standard of care for this procedure. The XXXX adverse determination letter indicated that the request for cervical spine MRI was non-authorized as authorization had been given for a cervical MRI in the past, and the submitted clinical documentation did not provide any date to indicate the presence of new changes on the neurologic exam to support the medical necessity of this request. The XXXX pain management note indicated that the claimant had worsening right arm and neck pain, as well as a prior cervical fusion. XXXX was desperate for pain relief and was an ideal candidate for cervical spinal cord stimulator. However, XXXX needed a cervical MRI prior to placement of spinal cord stimulator leads. The cervical MRI was required to assess for cervical pathology that would preclude placement of spinal cord stimulator leads.

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

The prospective request for cervical spine MRI w/o contrast-72141 is medically necessary. The denial of this request is overturned. The Official Disability Guidelines state that repeat cervical spine MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation).

This claimant presents with worsening right arm and neck pain. XXXX has right upper extremity burning numbness, signs of allodynia, discoloration, swelling, increased temperature and weakness in the right hand. XXXX has been diagnosed with CRPS Type 1 of the right upper extremity, confirmed by stellate ganglion blocks. XXXX is status post C5/6 cervical fusion in XXXX for spinal stenosis and cord impingement. XXXX has been recommended and psychologically cleared for a spinal cord stimulator trial. A cervical spine MRI has been requested to evaluate for cervical pathology that would impede spinal cord stimulator placement. The treating physician notes that cervical spine MRI has not been performed since the cervical fusion. Given the reported change in clinical picture relative to the industrial injury of XXXX, on-going neck and right upper extremity symptoms, and pending spinal cord stimulator trial, a repeat cervical spine MRI is indicated and consistent with the Official Disability Guidelines. Therefore, this request for cervical spine MRI w/o contrast-72141 is medically necessary.

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**
ODG Treatment
Integrated Treatment/Disability Duration Guidelines
Neck and Upper Back (Acute and Chronic)
Updated 10/12/17
Magnetic resonance imaging (MRI)

☐ **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)**