Maturus Software Technologies Corporation
DBA Matutech, Inc
881 Rock Street
New Braunfels, TX 78130
Phone: 800-929-9078
Fax: 800-570-9544

Notice of Independent Review Decision

March 11, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Cervical spine MRI

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 female who was at work on xx/xx/xx. At the time, she was driving a vehicle that had been disabled and was being pushed by another car. As she struggled to make a left turn without assistance to the power steering she had to use her body as leverage and started developing multitude of symptoms throughout her spine and extremities.

2013: On February 13, 2013, magnetic resonance imaging (MRI) of the cervical spine revealed C4-C5, C5-C6, and C6-C7 disc herniations and C4-C5, C5-C6 and C6-C7 mild right neural foraminal narrowing. An MRI of the lumbar spine revealed L3-L4, L4-L5 and L5-S1 disc herniation with L3-L4 and L4-L5 annular tear; L3-L4, L4-L5, and L5-S1 mild spinal canal stenosis and L5-S1 mild bilateral and L4-L5 mild left neural foraminal narrowing.

On November 19, 2013, , evaluated the patient for intermittent, stabbing, burning neck pain since the day of incident rated at 0-6/10; bilateral arm pain, numbness

and tingling radiating along the lateral aspect of the arm, radial forearm, pain in the hands as well as third, fourth and fifth fingers; constant stabbing, burning thoracic pain rated 5-7/10; constant lumbar stabbing sharp pain rated 5-7/10; bilateral legs electrical running pain, numbness and tingling, right greater than left along the buttocks, lateral thigh, popliteal fossa, heel and plantar aspect of the feet. The pain on the right side was rated at 4-7/10, and on the left 2-5/10. Past treatment included physical therapy (PT) which did not help, chiropractic treatment which worsened her symptoms, two epidural steroid injections (ESIs) that improved the right leg symptoms for two months but did not change any of her other symptoms. Review of systems was positive for joint/musculoskeletal symptoms and neurological symptoms. Upon examination of the neck, noted the head was held erect and perpendicular to the floor, moved in smooth coordination with the body motion; bilateral paravertebral muscular tenderness. Examination of the back revealed pain with extension of the back. Lower extremity deep tendon reflexes (DTRs) showed 0/4 posterior tibialis bilaterally and a positive straight leg raising (SLR) test on the right. obtained x-rays of the pelvis and thoracic spine that were normal. X-rays of the cervical spine revealed small posterior osteophytes at C5-C6. X-rays of the lumbar spine revealed facet arthropathy of the bilateral L5-S1 facets. diagnosed cervical sprain/strain, lumbar sprain/strain and thoracic sprain/strain. The recommendation was for proper body mechanics including no heavy lifting, keeping heavier objects closer to the body and no bending at the waist; ice/heat application to the affected area and home exercise program (HEP).

An MRI of the thoracic spine performed on November 22, 2013, revealed T9-T10 left paracentral 3-mm disc protrusion without focal impingement and endplate degenerative changes at T7-T8 and T9-T10.

On November 25, 2013, the patient reported continued pain complaints. noted increased pain with extension of benign-appearing calcifications, positive SLR on the right and 0/2 Achilles reflex on the right. The recommendation was a right L5-S1 discectomy and cervical ESI to relieve some pain.

2014: During February 5, 2014, follow-up the patient reported continued pain. Examination of the cervical spine revealed guarded painful ROM exacerbating quite easily with bilateral tilt and flexion, tenderness of the paraspinous muscles and some hyperesthesias along the right lateral deltoid. noted the prior request for ESI had been denied. The diagnoses were cervical sprain, cervical disc derangement, thoracic sprain and lumbar sprain. The claimant was encouraged to stay active, stretch regularly but avoid jarring motions or any type of heavy lifting. recommended appealing the denial.

On March 7, 2014, and April 1, 2014, noted the patient had continued symptoms. Her request for ESI was denied by Independent Review Organization (IRO). encouraged the patient to stay active, stretch regularly but avoid jarring motions or any type of heavy lifting.

On April 11, 2014, again recommended an ESI at the C4-C5 level. The patient was to maintain proper body mechanics and avoid heavy lifting.

On November 17, 2014, the patient was re-evaluated for continued constant stabbing pain. The pain easily triggered by any type of sudden movements or prolonged periods of inactivity. The upper extremity symptoms were almost equally aggressive along the lateral aspect of the arms, radial forearms, palm of the hands and the first and second fingers. The baseline pain was rated at 5-7/10. Current medications were listed as ibuprofen and gabapentin. Review of systems was positive for joint/musculoskeletal symptoms and neurological symptoms. Upon examination of the neck, noted the head was held erect and perpendicular to the floor. The head moved in smooth coordination with the body motion. There was bilateral paravertebral muscular tenderness. Examination of the back revealed pain with extension of the back. Sensory examination of the upper extremities revealed hyperesthesia in the left C5 distribution. Lower extremity DTRs showed 0/4 posterior tibialis bilaterally, and a positive SLR test on the right. recommended a C4-C5 ESI.

On December 12, 2014, the request for MRI of the cervical spine was denied with the following rationale: "*At the present time, for the described medical situation, Official Disability Length would not support this specific request to be one of medical necessity. This reference would not support this request to be one of medical necessity as the submitted documentation does not provide any data to indicate the presence of any new changes on neurological examination compared to previous to support a medical necessity for the requested diagnostic study. As such, presently, medical necessity for this request is not established."*

On December 29, 2014, the patient was re-evaluated. The patient's neck and upper extremity complaints were unchanged. She also reported intermittent lumbar pain trigger with prolonged periods of activity, bending forward, lifting or climbing stairs. The pain was rated at 0-5/10. The lower extremity symptoms with sporadic pulling sensation through the posterior aspect right more than left was reported. appealed the denial of C4-C5 ESI. He recommended repeat cervical MRI since the last time the patient had the MRI was in February 2013, where multiple disc herniations were identified. More current information was needed in order to support a better plan of treatment for the patient. also ordered bilateral lower extremity EMG and NCS to evaluate the patient's neurological conditions.

2015: On January 21, 2015, the appeal for MRI of the cervical spine was denied with the following rationale: "*ODG guidelines indications for MRI include: 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; Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain); Known cervical spine trauma: equivocal or positive plain films with neurological deficit. In this case, from the information that is available it is unclear if there have been changes since the initial MRI was done. Although there are herniated nucleus pulposus at three levels, they are not detailed in terms of size and neural compromise. The patient has neurological deficits and if these have not changed since the MRI, then another one will not benefit the patient's treatment. If the changes have occurred since the MRI, then a new one*

would be in order. Without this information an MRI is not warranted at this time. Therefore, the requested reconsideration MRI without contrast of the cervical spine is not medically necessary or appropriate."

On January 30, 2015, the patient reported continued, constant stabbing neck pain, easily triggered by any type of sudden movements or prolonged periods of activity, upper extremity radicular symptoms along the lateral aspect of the arms, radial forearms, palm of the hands and first and second fingers. The pain was rated at 5-7/10. She also complained of intermittent lumbar pain triggered with prolonged periods of activity, bending forward, lifting or climbing stairs. This pain was rated 0-5/10, lower extremity radicular symptoms with sporadic pulling sensation through the posterior aspect, right more than the left. Examination was unchanged. recommended the patient to stay active, stretch regularly but avoid heavy lifting. The patient was to file for a benefits review hearing.

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

The Official Disability Guidelines state 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). There is no evidence in the medical records indicating the criteria have been met and therefore; the decision is upheld.

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