MEDICAL REVIEW OF TEXAS

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DATE OF REVIEW: **DECEMBER 20, 2007**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Repeat MRI of the Cervical Spine

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
MD, Board Certified in Family Practice

REVIEW OUTCOME

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

X Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. non-authorization letter dated 11/26/07 and 11/20/07 including ODG guidelines;
2. letter dated 12/5/07 upholding non-authorization;
3. Dr. clinical notes;
4. Electrodiagnostic study by Dr. on 4/25/07;
5. FCE on 10/15/07 per Dr.
6. MRI report on thoracic spine;
7. Procedure notes on Thoracic T6-7 ESI on 9/20/07 and 10/15/07;
8. Dr. progress notes from 8/16/07 and 8/20/07;
9. TWCC forms for multiple dates;
10. Note from Dr. on 8/14/07; and
11. Multiple notes from Dr.

PATIENT CLINICAL HISTORY [SUMMARY]:
Patient was assaulted by a student on xx/xx/xx. She had initial spinal x-rays and was treated with chiropractic care, physical therapy, medications, ice, heat, rest, and ESI. She had a C-spine and T-spine MRI. Only the T-spine MRI results were submitted. Patient had successful results from her two ESIs, but symptoms were not totally alleviated. A request for a repeat C-spine MRI was not authorized.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
ALTHOUGH THE RESULTS OF THE INITIAL C-SPINE MRI WAS NOT SUBMITTED, THERE IS NO DOCUMENTATION TO SUPPORT THE MEDICAL NECESSITY OF ANOTHER MRI OF THE CERVICAL SPINE. THERE WAS NO DETERIORATION OF THE PATIENT'S NEUROLOGICAL STATUS RELATING TO THE CERVICAL SPINE. NO "RED FLAGS" OR WORRISOME WARNING SIGNS WERE NOTED IN THE RECORDS SUBMITTED FOR REVIEW. THERE ALSO IS NO DOCUMENTATION THAT THE ORIGINAL MRI WAS SO TECHNICALLY POOR THAT A REPEAT MRI WAS NECESSARY. THEREFORE, NO JUSTIFICATION WAS DOCUMENTED TO REPEAT AN MRI OF THE CERVICAL SPINE.

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

X **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

X **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**
- [x] **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)**