

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 02/26/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical MRI

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

Board Certified in Neurology

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)

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

An operative report from D.O. dated 08/08/00
An evaluation with P.A.-C. and Dr. dated 08/18/00
Evaluations with P.A.-C. for D. dated 10/10/00, 06/27/01, 07/13/01, 08/08/01, 07/09/03, 10/16/03, 07/01/04, and 10/07/04
Evaluations with R.N. for Dr. dated 04/04/02, 07/09/02, 08/06/02, 01/06/03, and 04/25/05
An EMG/NCV study interpreted by Dr. dated 08/20/02
An MRI of the cervical spine interpreted by M.D. dated 10/21/02
An evaluation with P.A.-C. for Dr. dated 04/10/03

A Required Medical Evaluation (RME) with D.O. dated 07/25/03
Letters written by Dr. dated 11/21/03 and 12/29/06
An evaluation with M.D. dated 12/18/03
A procedure note from Dr. dated 01/07/04
An evaluation with P.A.-C. for Dr. dated 02/20/04
A Required Medical Evaluation (RME) with M.D. dated 06/03/05
Procedure notes with Dr. dated 06/10/05, 07/12/05, 09/13/05, 10/21/05,
12/02/05, 03/07/06, 06/06/06, 08/08/06, and 11/10/06
An evaluation with Dr. dated 11/28/06
Letters of non-authorization from dated 12/27/06, 12/28/06, 01/08/07, and
01/09/07

PATIENT CLINICAL HISTORY [SUMMARY]:

On 08/08/00, Dr. performed a C6-C7 epidural steroid injection (ESI). On 08/18/00, Mr. recommended a second ESI. On 10/10/00, Mr. recommended continued use of Lortab, Lithium, Ativan, Prozac, and Beconase. On 06/27/01, Mr. referred the patient back to Dr. On 08/08/01, Mr. recommended a myelogram. On 04/04/02, Ms. recommended continued medications. An EMG/NCV study interpreted by Dr. on 08/20/02 revealed chronic C6 radiculopathy on the right. An MRI of the cervical spine interpreted by Dr. on 10/21/02 revealed a disc herniation at C6-C7. On 07/09/03, Mr. recommended an RME. On 07/25/03, Dr. recommended cervical surgery. On 12/18/03, Dr. further interventional pain management techniques prior to surgery. On 01/07/04, Dr. performed a bilateral C5-C7 transforaminal injection. On 10/07/04, Mr. recommended a surgical consultation. On 04/25/05, Ms. recommended repeat ESIs, along with samples of Skelaxin. Dr. performed cervical ESIs on 06/10/05, 07/12/05, 09/13/05, 10/21/05, 12/02/05, 03/07/06, 06/06/06, 08/08/06, and 11/10/06. On 11/28/06, Dr. recommended a Medrol Dosepak. There were letters of non-authorization for a cervical MRI from dated 12/27/06, 12/28/06, 01/08/07, and 01/09/07. On 12/29/06, Dr. wrote a letter of appeal for the MRI.

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

I find no indication to repeat the cervical MRI scan. This patient has responded to conservative treatment. He has well documented studies including a cervical MRI scan on 10/21/02 showing a moderated sized herniated disc at C6-C7 on the right, causing neural foraminal stenosis, which would explain his current symptoms. He had an EMG nerve study on 08/20/02, which showed a chronic radiculopathy at C6 on the right. While surgery is being considered strongly, there is no indication to do a repeat MRI scan for this patient's chronic right C6 radiculopathy that is well documented by previous imaging studies and electrodiagnostic studies. Therefore, in my opinion, a cervical MRI scan is not

reasonable or necessary as related to the compensable injury for the reasons stated above.

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**
- 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)**

