

I-Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 10, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat Cervical MRI without Contrast

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

MD, Board Certified Orthopedic Surgeon

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.

The reviewer finds that medical necessity does not exist for Repeat Cervical MRI without Contrast.

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx-year-old female with complaints of back pain and neck pain. She was previously recommended to have an intrathecal morphine pump for her lumbar spine complaints. She has had multiple lumbar spine surgeries. She has had previous MRI scan in February 2007. She has complaints of neck pain and back pain, and the patient feels she needs further investigation of her neck complaints, based upon her letter. Current request is for repeat cervical MRI scan without contrast.

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

This is a patient with a multiplicity of problems, previous multiple lumbar surgeries as well as previous anterior cervical discectomy and fusion. She had multilevel degenerative changes seen on her cervical spine and MRI scan. There is no evidence in the records reviewed of repeat surgical indication for her cervical area that would warrant a repeat cervical MRI scan. There is no evidence in the medical records of any impending neurological deficit or of any myopathic complaints. Given that there is nothing in the medical records to show there has been any interim progress between the previous MRI scan and the one currently being recommended, and nor is there any indication in the medical records that surgery should be considered for her cervical area, the patient does not meet the ODG Guidelines for the requested procedure. The reviewer finds that medical necessity does not exist for Repeat Cervical MRI without Contrast.

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)