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Notice of Independent Review Decision

Date of Review: 07-10-2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI cervical spine with/without contrast

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

Certified by the American Board of Orthopaedic Surgery, and fellowship-trained in surgery of the spine

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)

Injury date	Claim #	Review Type	ICD-9 DSMV	Upheld/ Overturned
		Prospective	723.4	Overturned

PATIENT CLINICAL HISTORY:

The claimant is a xx-year-old female who injured her right arm on xx/xx/xx, when pulling on a cart that had a wheel stuck in an elevator door opening. The initial diagnosis was muscle strain. The patient had persistent pain in her right arm and

hand with numbness and tingling, and underwent right forearm tendon repair in 9/1999. She had continuing pain above and below the elbow, for which she had further surgery in 5/2000. In 6/2000 the records noted complaints of neck pain radiating to her right shoulder area. Cervical spine imaging studies showed degenerative changes and disc protrusion, and she had anterior cervical discectomy surgery with fusion at C4-C5-C6 in 11/2001. She continued to have neck pain and bilateral upper extremity pain, with weakness and numbness in her upper extremities. She has had steroid injections and narcotic pain medications for the pain.

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

In the opinion of the Reviewer the request for a cervical spine MRI with/without contrast is medically necessary and should be authorized. The Reviewer noted that the patient meets the ODG guidelines that provide for MRI imaging when the patient has severe neck pain with radiculopathy, or chronic neck pain (after 3 months of conservative treatment) with spondylosis or radiograph and neurologic signs or symptom.

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)**