

IRO Express Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: October 27, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat cervical MRI

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

Board Certified in Physical Medicine and Rehabilitation

Subspecialty Board Certified in Pain Management

Residency Training PMR and ORTHOPAEDIC SURGERY

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Denial Letters 9/23/08 and 10/9/08

Records from Dr. 1/2/07 thru 10/16/08

MRI 4/23/05

Letter 10/21/08

DDE 7/3/08

PATIENT CLINICAL HISTORY [SUMMARY]:

Most of the material provided related to physician visits for shoulder pain. Passing comments on the same page included low back and SI pain, knee pain and a note dated (month not clear/5/07 "exacerbation of old cervical disc disease." The MRI report from

April 23, 2005 was for the shoulder demonstrating a tear of “the suprapinatus tendon at its insertion on to the femoral head.”

The prior denials commented upon this man with a work related injury in xxxx. He had a fusion at C4/5, C5/6, and C6/7, but the Reviewer does not know when this was presented. The reviewers noted that the MRI performed on 6/15/07 showed postoperative changes with disc bulges at the C5/6, C6/7 and C7/T1 levels. These reviewers did not cite any new disc herniation.

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

The material provided from Dr. only superficially commented about the cervical problems. There is the 2007 comment of an exacerbation of the prior disc problems. In turn, most of the information about the cervical spine was provided in the comments of the prior reviewers. These included an MRI a year ago. There was no information of any new neurological loss to warrant a new MRI. Most of the ODG comments are directed at acute issues. It recognizes that an MRI would be appropriate for a chronic condition if its accompanied by neurological changes. None were mentioned by Dr.

Magnetic resonance imaging (MRI)

Not recommended except for indications list below.... **Patients with normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging...**

Indications for imaging -- MRI (magnetic resonance imaging):

- 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**
- **Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present**
- **Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present**
- Chronic neck pain, radiographs show bone or disc margin destruction
- Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal"
- **Known cervical spine trauma: equivocal or positive plain films with neurological deficit.”**

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)**