

I-Resolutions Inc.

An Independent Review Organization
71 Court Street
Belfast, ME 04915
Phone: (512) 782-4415
Fax: (512) 233-5110
Email: manager@i-resolutions.com

DATE OF REVIEW:

Apr/15/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical MRI

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

M.D., 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines
URA Denial Letters, 03/04/08, 03/16/09
Office notes, Dr. 01/22/07, 10/17/08, 02/18/09
Peer review, Dr., 10/27/08

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female injured on xx-xx-xx in a slip and fall. On 01/22/07 Dr. saw the claimant for pain in the right arm to right mid back, numbness and weakness for 2 months. On examination there was no motor or sensory deficit. Reflexes were symmetrical. She had a normal gait. Cervical motion was "decreased" and painful. There was tenderness of trapezius, bilateral deltoid and right scapulothoracic region and right chest wall. An MRI of the cervical spine and right elbow, x-rays of the chest and ribs and a cervical epidural steroid injection as well as Naprosyn and rehabilitation were the recommendation.

The claimant was seen on 10/17/08 by Dr. for ongoing pain. The examination documented increased cervical lordosis with restricted and painful motion, spasm of the paravertebral, facet area, trapezius and scapulocostal area as well as trigger points. Cervical MRI was recommended.

On 02/18/09 Dr. noted the claimant had ongoing neck and right shoulder pain. The neurological examination was reported as non focal and was otherwise unchanged. A cervical MRI was once again recommended. The claimant was started on Celebrex at that time.

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

The reviewer finds that the requested cervical spine MRI is medically necessary based on review of this medical record.

This claimant has medical records from 01/22/07 through 02/18/09 by Dr. that document neck pain, limited motion and intermittent spasm. Dr. does not document specific x-ray findings yet does document a failure of conservative care to include anti-inflammatory medication and epidural steroid injection. He also documents spasm, trigger pointing and limited motion.

ODG guidelines document the use of an MRI for testing in patients who have chronic neck pain and possible radiculopathy or other positive physical findings.

In light of the fact that the office records of Dr. span more than two years and it does not appear that a cervical spine MRI has ever been performed, then a cervical spine MRI at this time would be medically necessary.

Official Disability Guidelines Treatment in Worker's Comp 2009 Neck and Upper Back

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-AMERICA 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)