

SENT VIA EMAIL OR FAX ON
May/05/2009

Applied Resolutions LLC

An Independent Review Organization
1124 N Fielder Rd, #179
Arlington, TX 76012
Phone: (512) 772-1863
Fax: (512) 853-4329
Email: manager@applied-resolutions.com

DATE OF REVIEW:

Apr/28/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical MRI without contrast

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

Board Certified Neurologist with 30 years experience in clinical practice

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 3/13/09 and 3/24/09
- 3/13/09 and 3/23/09
- Dr. 5/12/08 thru 3/5/09
- OP Reports 10/3/08 and 6/9/08
- Radiology Reports 10/1/08

PATIENT CLINICAL HISTORY SUMMARY

The records show a successful cervical fusion with improvement in the previous neurological deficit. The abnormal physical findings are now limited to para-cervical muscle spasm and decreased range of motion of the neck. Neurological deficits have resolved according to Dr. notes.

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

No mention is made of any new injury. No mention is made in the treating notes of the patient's current activities during the day that may be contributing to cervical sprain e.g. is he driving, carrying or sitting at a computer for long periods? No mention is made of how he is sleeping e.g. is he tossing and turning? In view of the positive signs noted (suggesting symptom magnification), one should be careful to exclude activity that the patient may be

doing to aggravate his condition. There are other issues to look into before suspecting a failure of the cervical fusion. Therefore, the MRI is not medically necessary at this time.

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)