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Notice of Independent Review Decision

DATE OF REVIEW: 07/13/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical MRI

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

Board Certified in Orthopedic 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)

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.

Cervical MRI - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with M.D. dated 05/07/09, 05/18/09, 05/21/09, 05/29/09, 06/05/09,
and 06/18/09

A letter of non-certification, according to the Official Disability Guidelines (ODG), from D.O. dated 05/13/09

X-rays of the cervical spine interpreted by Dr. (no credentials were listed) dated 05/19/09

A letter of non-certification, according to the ODG, from M.D. dated 06/01/09

The ODG Guidelines were provided by the carrier

PATIENT CLINICAL HISTORY

On 05/13/09, Dr. wrote a letter of non-authorization for a cervical MRI. Cervical x-rays interpreted by Dr. on 05/19/09 revealed mild spondylosis along the anterior aspect of the mid cervical spine. On 06/01/09, Dr. also wrote a letter of non-certification for a cervical MRI.

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

The patient does not have a neurological emergency. He does not have any evidence of progressive motor loss. There is no evidence of tumor or infection. In the absence of these emergent indications, the ODG would indicate that conservative care, including anti-inflammatory medications and physical therapy be begun. Most references ask for a minimum of six weeks of conservative care prior to ordering an advanced study such as an MRI. The mere presence of numbness does not confirm the clinical diagnosis of radiculopathy. It is not necessary to obtain an MRI until adequate treatment has been obtained. This patient does not meet the ODG criteria for a cervical MRI. Therefore, the requested cervical MRI is neither reasonable nor necessary and the previous adverse determinations should be upheld.

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 AND KNOWLEDGE BASE
- 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)**