



DATE OF REVIEW: 07/08/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:

Repeat MRI scan, cervical spine

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of the patient suffering spinal injury

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. ZRC forms
2. TDI referral forms
3. Denial letters, 04/20/09 and 06/05/09
4. Requestor records
5. Clinical notes dated 05/04/09, 04/17/09, 03/24/09, 01/15/09, 11/07/08
6. Designated Doctor Evaluation, 03/26/09
7. Operative report, 03/09/09
8. History and physical examination, 03/09/09
9. EMG/nerve conduction study report, 12/15/08
10. MRI scan, 02/04/08
11. URA records
12. letters dated 04/21/09 and 06/05/09
13. Fax cover sheets

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This is a male who suffered an injury to his face, neck, and leg when he was pushed into a shelf, suffering a direct blow injury on xx/xx/xx. He was initially evaluated and treated

conservatively for cervical strain syndrome. He has suffered persistent pain in the cervical spine, right shoulder, and right arm. An MRI scan performed 02/04/08 revealed mild cervical spondylosis without evidence of specific herniated nucleus pulposus or cervical stenosis. The EMG/nerve conduction study performed on 12/1/08 is reported to have revealed bilateral carpal tunnel syndrome and bilateral C6 chronic radiculopathy. The patient has received a recommendation for MRI scan. Preapproval requests were denied, reconsidered, and denied.

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

Throughout the clinical evaluations, the patient's principle finding has been the consistent complaint of pain. Limited neurological findings have been present and have been consistent. There has been some diminished sensation, no motor deficits, and deep tendon reflexes are generally described as diminished without being asymmetric. There has been no progression of neurological findings and no changes in neurological findings over the course of this patient's evaluation and treatment. A single epidural steroid injection failed to provide any benefit. The criteria for the performance of a repeat MRI scan have not been met as published in the ODG 2009 Neck and Upper Back Chapter.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

(Check any of the following that were used in the course of your review.)

- 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)