

SENT VIA EMAIL OR FAX ON  
May/04/2009

## True Resolutions Inc.

An Independent Review Organization  
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**DATE OF REVIEW:**

May/04/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Magnetic Resonance (eg, Proton) Imaging, Spinal Canal and Contents, without Contrast Material, followed by Contrast Material(s) and further Sequences; Cervical

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

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**

OD Guidelines

EMG, 03/18/04

DDE, Dr, 11/27/07

Office notes, Dr., 02/23/09, 03/23/09

Peer review, Dr., 03/02/09

Peer review, 03/30/09

03/03/08, 03/31/09

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male injured on xx-xx-xx. Records showed that the claimant had a subsequent ACDF at C5-6 and 6-7 in 01/03 and hardware removal with laminectomy in 09/03. A 03/18/04 EMG showed ongoing left C5-6 cervical radiculopathy and old left C7 radiculopathy.

On 11/27/07, Dr. saw the claimant for a designated doctor examination. The claimant reported pain in the bilateral shoulders and neck with intermittent wrist pain right more than left. On examination, the cervical motion was limited but there was questionable effort. He had normal 2-point discrimination with normal reflexes and normal strength.

A 02/23/09 letter by Dr. indicated the claimant had pain in the posterior neck and upper

thoracic spine, worse since his last visit. He also reported occasional numbness and paresthesia in both upper extremities but the neck pain was the chief complaint. The claimant was working as and taking no narcotics. An MRI was recommended. This was denied on peer review.

On 03/23/09, Dr. reported the claimant had pain in C7-T1 and could not sleep. He had occasional bilateral upper extremity numbness and paresthesia. The examination documented normal alignment with tenderness at C6-7 and C7-T1. There was stiffness in all planes of motion. He had a normal shoulder exam. Strength was 5/5 and sensation was intact. MRI was again recommended and denied.

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

The request for the cervical MRI cannot be recommended. The records for this xxxx injury are limited with no records present from 11/07 to 02/09. It is unclear how the claimant progressed in that time period and if he had any treatment during that time to include MRI scans. It is unclear if the claimant has had persistent neck pain from the 11/07 or whether there has been a more recent onset with change in symptoms. ODG would recommend plain films prior to an MRI and the records do not support that this has been done. There has been no documented conservative management such as a home exercise program and a period of routine dosing of an anti-inflammatory medication. Lastly, while it is understood that the claimant has pain, records do not support that he has a radicular pattern to the pain or that he has a new or evolving neurological deficit that would support the request for an MRI.

Official Disability Guidelines Treatment in Worker's Comp 2009 Neck and Upper Back-  
Magnetic resonance imaging (MRI)

**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)