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Notice of Independent Review Decision

DATE OF REVIEW: 11/09/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat MRI of the cervical spine

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.

Repeat MRI of the cervical spine - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

A TWCC-1 form dated 12/12/00

X-rays of the cervical spine, thoracic spine, and right shoulder interpreted by M.D. dated 12/14/00

Evaluations with D.C. dated 12/14/00, 12/28/00, 01/25/01, 02/02/01, 02/14/01, 02/20/01, 03/06/01, 03/20/01, 03/26/01, 04/16/01, 04/17/01, 05/07/01, 05/30/01, 06/12/01, 06/13/01, 07/03/01, 08/08/01, and 08/22/01

DWC-73 forms from M.D. dated 02/14/01 and 06/13/01

DWC-73 forms from Dr. dated 12/14/00, 11/25/01, 02/02/01, 03/06/01, 03/26/01, 04/16/01, 05/07/01, 05/30/01, 07/03/01, 08/08/01, and 08/22/01

Physical therapy evaluations with P.T. dated 12/19/00 and 02/02/01

Physical therapy with Mr. dated 01/12/01, 01/15/01, 01/16/01, 01/24/01, 01/25/01, 01/26/01, 01/28/01, 01/29/01, 01/30/01, 02/05/01, 02/07/01, 02/09/01, and 02/14/01

A Required Medical Evaluation (RME) with F.A.C.P., P.A. dated 05/08/01

A DWC-73 form from Dr. dated 05/08/01

An impairment rating evaluation with D.C. dated 07/31/01

MRIs of the cervical spine and right shoulder interpreted by , D.C. dated 08/06/01

X-rays of the cervical spine and shoulder interpreted by Dr. dated 08/06/01

An EMG/NCV study interpreted by M.D. dated 08/08/01

An MRI of the cervical spine interpreted by M.D. dated 12/07/05

Evaluations with an unknown provider (the signature was illegible) at Hospital dated 12/08/05, 03/20/06, and 04/27/06

An EMG/NCV study interpreted by an unknown provider (the signature was illegible) dated 03/21/06

An evaluation with M.D. dated 04/19/06

A Recorded Statement of the patient dated 12/17/08

A Request to Change Treating Physicians form dated 01/22/09

Evaluations with M.D. dated 02/09/09, 02/25/09, 05/01/09, 08/17/09, 09/14/09, and 09/21/09

An RME with M.D. dated 04/15/09

A letter of non-certification, according to the Official Disability Guidelines (ODG), from M.D. at dated 09/01/09

Physical therapy with P.T. dated 09/02/09 and 09/25/09

A letter of non-certification, according to the ODG, from M.D. at dated 09/18/09

The ODG Guidelines were provided by the carrier/URA

PATIENT CLINICAL HISTORY

X-rays of the cervical spine, thoracic spine, and right shoulder interpreted by Dr. on 12/14/00 were essentially unremarkable except for spondylitic changes at C6-C7 and AC joint hypertrophic changes of the shoulder. On 12/14/00, Dr. recommended physical therapy four times a week for two weeks. Physical therapy was performed with Mr. from 01/12/01 through 02/14/01 for a total of 13 sessions. On 05/08/01, Dr. placed the patient at Maximum Medical Improvement (MMI) at that time with a 6% whole person impairment rating. On 07/31/01, Dr. felt the patient was not at MMI. An MRI of the cervical spine interpreted by Dr. on 08/06/01 showed osteoarthritis from C3 through C6 and central canal stenosis and bilateral neural foraminal stenosis at C6-C7, as well as a disc protrusion. An MRI of the right shoulder interpreted by Dr. on 08/06/01 showed hypertrophy and

inflammation of the AC joint, lateral downsloping of the acromion, tendonitis of the supraspinatus tendon, mild subdeltoid bursitis, a possible glenoid labral tear, and a subchondral contusion versus degenerative subchondral cystic formation in the greater tuberosity. An EMG/NCV study interpreted by Dr. on 08/08/01 showed possible bilateral carpal tunnel surgery. An MRI of the cervical spine interpreted by Dr. on 12/07/05 was unremarkable. Another EMG/NCV study interpreted by an unknown provider on 03/21/06 showed mild ulnar neuropathy at the Guyon's canal and evidence consistent with a previous history of Guillain Barre. On 04/19/06, Dr. recommended continued Tylenol and a sling pass. On 04/15/09, Dr. felt no further treatment was indicated for the cervical spine based on the compensable injury and felt the current condition was not related to the original injury. On 08/17/09, Dr. recommended a cervical MRI. On 09/01/09, Dr. wrote a letter of denial for the cervical MRI. Physical therapy was performed with Ms. on 09/02/09 and 09/25/09. On 09/18/09, Dr. also wrote a letter of denial for the MRI.

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

The patient was injured in xx/xx when lifting. His workup at that time revealed degenerative changes with an MRI of the cervical spine on 06/06/01 demonstrating osteoarthritis and cervical stenosis. The patient's MRI was specifically stenotic at C6-C7. The patient had an electrodiagnostic study in 2006 that did not confirm radiculopathy, but instead confirmed ulnar neuropathy. While the patient does have increasing symptoms as of 02/09/09, he has predominantly axial pain. He has numbness in his thumbs and tingling in his arms. This is due to the natural progression of the degenerative disease that was noted in 2000. There has been no change in the claimant's neurological status in a recent examination to indicate a repeat MRI. Furthermore, there has been no significant change in his symptoms or evidence of a new injury. Therefore, the requested repeat MRI of the cervical spine is not reasonable or necessary and the previous adverse determinations should be upheld. Criteria utilized include the current medical literature, which indicates that even in the absence of injury, cervical degeneration worsens over time and this patient's findings are consistent wholly with degeneration.

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)**