

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Sep/01/2009

**IRO CASE #:**

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

MRI Cervical with and without Contrast

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

MD, 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination letters, 07/16/09, 07/27/09

Operative reports, 06/30/08, 05/28/08, 05/05/08

Law Firm Letter, 08/28/09

Neurosurgical consultation, 07/27/09

Dr., M.D., 07/09/09, 11/18/08

Dr., M.D., 08/25/08

Dr., 03/06/09, 05/05/09

Dr., M.D., 10/16/08, 10/27/08

Dr., 02/25/08

MRI scan of cervical, 12/21/07

CT scan of cervical spine, 07/27/09

Cervical myelogram, 05/09/08

CT scan post myelogram, cervical, 05/09/08

Episcopal, 08/23/08

EMG, 10/21/08

Myelogram, cervical, 08/27/08

CT scan cervical, 08/27/08

ODG Guidelines and Treatment Guidelines

**PATIENT CLINICAL HISTORY SUMMARY**

This is a patient who has undergone multiple surgeries. Initially he had a two-level discectomy followed by neural foraminotomies. He has had various pain management procedures. Records indicate he has chronic pain. This particular request was designated life-threatening; however, there is no indication from the medical records as to why this is the case. There is a recent MRI scan as well as a CT scan, which do not show any obvious life-threatening pathology. Request is for a repeat MRI scan with and without gadolinium.

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

There have already been very recent studies conducted in this case. There is an absence of explanation in the medical records as to why further imaging is needed, especially given the technical decompressions that have been performed. This patient does not meet ODG Guidelines. There is no clinical justification for this repeat study in the records. There is no indication in the records that there was latent infection. There is no evidence from the neurological examination that there is any sort of myelopathy or progressive neurological deficit. For this reason, the previous adverse determination cannot be overturned. The reviewer finds that medical necessity does not exist for MRI Cervical with and without Contrast.

**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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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