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IRO Certificate

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 9/3/09

**IRO CASE #:**

Description of the Service or Services In Dispute  
Cervical MRI without contrast

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

Physician Board certified in Neurological Surgery

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

<b>X Upheld</b>	(Agree)
Overturned	(Disagree)
Partially Overturned	(Agree in part/Disagree in part)

Description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse determination letters, 8/19/09, 6/22/09, 7/14/09, 7/17/09  
Pain management reports, 8/08-7/09, Dr.  
Cervical MRI report 4/7/06  
Operative report facet blocks 4/7/09  
ODG guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a xx –year-old male who in xx/xx was involved in a motor vehicle accident. He developed neck, chest and right shoulder pain. The initial treatment is not well documented in the reports provided for this review. Of late, physical therapy, medications and rest have not been helpful. A 4/7/06 MRI showed multilevel disk problems without significant stenosis of the spinal canal or the foramina. There was nothing to suggest myelopathy, such as a spinal cord signal. The patient has been helped by cervical epidural steroid injections in the past, but the pain has consistently returned. Hyperactivity of reflexes suggesting possible myelopathy have been reported. Atrophic changes, especially in the left upper extremity have also been reported. A definite, complete neurologic examination is not present in any of the records provided for this review. It was noted that the patient needs a neurological examination and that an MRI is required for such a referral. I agree that a neurological examination is necessary, and I know of no requirement for an MRI prior to that.

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

I agree with the denial of the requested cervical MRI at this time. The examinations provided for this review are so varied and indefinite in regard to the presence of radiculopathy or myelopathy that neurosurgical evaluation should be obtained prior to MRI testing. It is likely that such evaluation will lead to a repeat cervical MRI, especially in view of the fact that the patient has not had one in over three years, and there are some questionable changes to suggest progression of difficulty in the cervical spine secondary to the changes which occurred secondary to the injuries that he sustain superimposed on the chronic changes in his cervical spine that were present at the time of injury.

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

- 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 NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)