

SENT VIA EMAIL OR FAX ON
Nov/29/2010

True Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (214) 717-4260
Fax: (214) 276-1904
Email: rm@trueresolutionsinc.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/29/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Magnetic Resonance (EG, Proton) Imaging, Spinal Canal and contents, Cervical; without contrast material

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

Board certified in Physical Medicine and Rehabilitation with expertise in pain management, wound management and geriatrics. Medical Director of Rehabilitation.

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

Denial Letters 10/7/10, 11/8/10, 11/10/10

10/6/10, 11/10/10, 9/20/10, 9/27/10

Sport & Spine 9/13/10 and 8/16/10

MRI 8/11/10

Rehab 8/18/10 thru 9/1/10

PATIENT CLINICAL HISTORY SUMMARY

This claimant was involved in an MVA on xx/xx/xx. The initial complaint was knee pain. On 8/18/2010 a Rehabilitation note indicates that patient did not complain of neck pain. There has not been 3 months of conservative treatment for neck pain documented. There is not evidence of worsening neck pain. There are no neurologic findings. On 9/13/2010 the PA indicates the patient has right-sided intrascapular neck pain with radiation to the shoulder.

The patient at that time complained of decreased range of motion. The PA indicates it is mainly muscular type pain. There are no radiographs to review.

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

The ODG guidelines indicate that a cervical MRI should be considered for chronic neck pain after 3 months of conservative treatment has failed and there are normal radiographs. No x-rays are available. There is not documentation of failed treatment with therapy or medication management. The request is not supported by ODG.

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)