

Core 400 LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Dec/22/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical MRI

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

ODG Guidelines and Treatment Guidelines

MRI Left Shoulder, 08/25/08

MRI cervical spine, 01/12/09

Operative Report, 04/14/09

FCE, 08/11/09

Office note, 08/19/09

Office note, Spear, PA-C, 09/03/09

Report of Medical Evaluation, Dr. 09/17/09

EMG/NCV, 09/17/09

Office note, , PA, 09/25/09

Peer Review, 10/01/09

Peer Review, 10/09/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a, right hand dominant pipe finisher who injured his left shoulder after a slip and fall on xx/xx/xx. He was diagnosed with left shoulder impingement, acromioclavicular joint inflammation and a rotator cuff tear. An MRI of the cervical spine on 01/12/09 demonstrated disk bulges and/or broad-based herniations at multiple levels with mild central stenosis predicted at C6-7. There were varying degrees of foraminal narrowing, primarily at C4-5, C5-6 and C6-7 which were slightly eccentric on the left. No fracture, subluxations or focal cord lesions were identified. On 04/14/09 he underwent a left shoulder open subarticular decompression, distal clavicle resection and rotator cuff repair.

A functional capacity evaluation was performed on 08/11/09. The claimant was unemployed and demonstrated variable levels of physical effort and minor inconsistency to

reliability/accuracy of his subjective reports of pain/limitation; considered minor with subjective reports generally matching well with distraction-based clinical observations. He gave full physical effort. He demonstrated the ability to perform some but not all the physical requirements of medium work with restrictions on lifting activities. He did not plan on returning to his previous work as a job was not available for him.

He was referred for vocational rehabilitation. Dr. xxxxx saw the claimant on 08/19/09 for discomfort of the left shoulder with numbness and tingling in his hand and occasional neck pain. He had discomfort on extremes of motion and his arm was neurocirculatory stable. He was felt to be at maximum medical improvement with the ability to do medium work with restrictions. A home exercise program was advised. Dr. xxxxx saw the claimant on 09/17/09 noting mild pain, loss of motion and strength above shoulder level. He was declared at maximum medical improvement as of 09/17/09 and assigned a 5 percent whole person impairment rating.

EMG/NCV studies on 09/17/09 showed evidence of a C7 radiculopathy on the left. xxxxx, PA saw the claimant on 09/25/09 noting ongoing shoulder pain with movement and pain from his neck going down the shoulder. He was doing work conditioning. An examination was not performed. A cervical MRI was recommended. This was denied on two reviews 10/01/09 and 10/09/09 and is currently under dispute.

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

The evidence-based ODG guidelines recommend imaging studies for individuals with chronic neck pain in excess of three months and/or signs of radiculopathy or progressive neurologic deficit. Repeat studies are reserved for individuals with long standing symptoms without recent studies and obvious clinical change such as progressive neurologic deficit or suggestion of new injury. In this case, there is a recent MRI scan from January of 2009. There are more recent EMGs from September 2009 that suggest there is evidence of radiculopathy on the left side. The physician assistant for Dr. xxxxx has recommended an MRI scan but has not discussed why that particular study is indicated and how that will change ongoing treatment. The two previous reviewers did not find evidence to suggest objective findings on examination and/or more importantly a clinical change to recommend the additional imaging studies. This reviewer would concur, and thus, based on the evidence-based literature, I could not recommend the treatment as being reasonable and medically necessary. The reviewer finds that medical necessity does not exist for Cervical MRI.

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, (i.e. Neck – MRI)

ODG – Cervical Spine - Indications for imaging -- MRI (magnetic resonance imaging)

- Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present
- Neck pain with radiculopathy if severe or progressive neurologic deficit
- Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present
- Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present
- Chronic neck pain, radiographs show bone or disc margin destruction
- Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal"
- Known cervical spine trauma: equivocal or positive plain films with neurological deficit

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)