

SENT VIA EMAIL OR FAX ON
Mar/07/2011

True Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/05/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat Cervical MRI with and without contrast

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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

Dr. 12/27/10

MRI 4/17/07

Dr. 7/9/08

OP Reports 5/25/07 and 9/12/07

CPMP Notes 8/7/08 thru 11/11/08

PATIENT CLINICAL HISTORY SUMMARY

This is a male with a date of injury xx/xxxx, when he fell into a ditch. He developed a myelopathy. He underwent an ACDF at C3-C4 and C6-C7 in 05/2007. On 09/12/2007 he underwent a left L3-L4 and L4-L5 laminectomy, and foraminotomy. He has been under chronic pain management and has not had any scans since his surgery. He complains of neck, bilateral shoulder and arm pain, particularly to the right. He also has a feeling of numbness and weakness in all 4 extremities. He has seen a chiropractor and is on multiple medications. His examination 12/27/2010 a mild Lhermitte phenomenon with movement of the neck. He has a somewhat wide-based gait. There is some mild generalized loss of strength in all four extremities.

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

The MRI of the cervical spine is not medically necessary. According to the ODG, "Low Back" chapter, "repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation)". There is no evidence that the claimant has any progression of neurological deficits or has had any significant change in his symptoms. In this case, there is very little to suggest, by examination or by history that the claimant is suffering from new or progressive neurologic deficits that warrant additional neuroimaging. Further insight is needed as to why a repeat MRI is medically necessary and how this will impact his care.

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)