

# US Resolutions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Oct/24/2011

**IRO CASE #:**

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

MRI Cervical Spine W/O Contrast

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

M.D., Board Certified Physical Medicine and 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**

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a female who is reported to have a date of injury of xx/xx/xx. The record indicates that the claimant was under the care of and that the claimant was referred for psychological evaluation on 02/01/10. It is reported that the claimant works in an administrative position and due to the poor ergonomics of her workstation she began to experience pain in her neck and her shoulder. She also reports pain that began radiating from her lower back and into her legs. At this time, the claimant is reported to be taking Lyrica, Xanax, and Motrin. Her Beck depression inventory was 0. Her Beck anxiety inventory was 8. She was opined to have a chronic pain syndrome. It was recommended she participate in a work-conditioning program. The record contains a clinical note from dated 04/13/11 in which she presents for low back pain, leg pain, right-sided cervical pain and right-sided arm pain. She has complaints of pain in the neck radiating down her right arm. Her last MRI was done in 2003. She is noted to use Biofreeze and Voltaren Gel. She has had no interventional pain therapy. Deep tendon reflexes are normal in the upper extremities. Strength is normal. She is reported to have a positive Spurling's to the right. There is a recommendation that she undergo a repeat MRI of the cervical spine. On 08/24/11, no detailed physical examination is documented. The claimant has significant subjective complaints.

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

The request for repeat MRI was reviewed by on 09/14/11. non-certifies the request noting that the mechanism of injury is not described. He notes that the claimant has complaints of low back pain, leg pain, right-sided cervical pain, and right-sided arm pain. The claimant is reported to have undergone MRI in 2003, but no radiology report was submitted for review. He notes that there is no detail physical examination with evidence of progressive neurologic deficits or significant changes in symptoms to support the determination of medical necessity for repeat MRI.

The appeal request was reviewed by notes that repeat imaging is encouraged if there is change of motor sensory findings over time. She notes that MRI was done in 2003, but the results are nowhere to be seen and therefore impingement is not well documented in the 2003 studies, and therefore, the medical necessity is not established. There is no information in the records reviewed that conflicts with the above analysis and after reviewing the submitted records, the reviewer agrees with the prior determinations. Therefore, and based upon the submitted clinical information, the previous utilization review determinations are upheld, as the medical necessity for MRI Cervical Spine W/O Contrast is not established per the Official Disability Guidelines.

**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)