

# I-Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Aug/20/2012

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

cervical MRI including 72141

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

M.D., Board Certified Orthopedic Surgery

**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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** The reviewer finds the requested cervical MRI including 72141 is not supported as medically necessary.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines

Emergency room report 04/27/12

CT chest 04/27/12

CT brain 04/27/12

Orthopedic consult 05/22/12

MRI left shoulder 05/09/12

Clinical orthopedic evaluation 06/26/12

Prior reviews 07/03/12 and 07/11/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who was in a motor vehicle accident on xx/xx/xx. The patient was initially seen in the emergency room on the date of injury with complaints of pain in the upper back and left shoulder. The patient denied any neck pain and the initial physical examination revealed no upper or lower sensory or motor deficits. CT of the head and chest were unremarkable for trauma. There was a deep laceration to the posterior ear that is almost an avulsion. MRI of the left shoulder dated 05/09/12 revealed moderate glenohumeral joint effusion with small irregular loose bodies in the subscapularis recess. On orthopedic evaluation dated 05/22/12 it is stated that the patient developed back pain in the upper thoracic region as well as low back pain without any radiating pain. Physical examination revealed stiffness with active range of motion in the left shoulder. Positive Speed's and O'Brien's tests were noted. The patient was placed on Celebrex and continued with Norco

and referred for physical therapy. The patient did undergo a left subacromial space injection. Follow up on 06/26/12 stated the patient had transient benefits with the left subacromial injection. The patient also reported paracervical pain and reported intermittent numbness and tingling in the thumb and index fingers. Physical examination revealed diffuse tenderness and paraspinal spasms. Spurling's was negative and no focal neurological deficits were reported. MRI studies were recommended to rule out radiculopathy. The request for MRI of the cervical spine was denied by utilization review on 07/03/12 as there was no indications of neurological deficit that would support the request. The request for MRI of the cervical spine was again denied by utilization review due to lack of objective evidence regarding neurological deficit or radiculopathy. A third denial for the MRI of the lumbar spine dated 07/11/12 stated there were no plain film radiographs of the cervical spine and no neurological deficits.

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

The clinical documentation demonstrates the patient complained of neck pain with no radiating symptoms. There was intermittent numbness in the thumb and forefinger of the hands. However, the patient's physical examinations did not reveal any evidence of focal neurological deficits. There were no plain film radiographs of the cervical spine provided for review that were non-diagnostic. Current evidence based guidelines recommend the use of MRI studies when there is evidence of severe or progressive neurological deficits or evidence of significant trauma. Given the lack of any objective findings regarding severe trauma or neurological deficit of the upper extremities, MRI studies would not be indicated per the guidelines. The reviewer finds the requested cervical MRI including 72141 is not supported as medically necessary.

**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)