

# C-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jan/26/2012

**IRO CASE #:**

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

cervical MRI without contrast

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

M.D., Board Certified Pain Medicine

**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**

Official Disability Guidelines, Upper Neck and Back Chapter

Pre-authorization review 11/30/11

Notification of reconsideration adverse determination 12/29/11

Pre-authorization request for cervical MRI 11/30/11

Pre-authorization request 12/14/11

Office notes 11/03/11 through 01/11/12

Physical therapy notes 11/07/11

X-rays cervical spine 11/03/11

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a female nurse manager whose date of injury is xx/xx/xx. She was pulling a bed out of a room and pushing it into another room and felt a pop in her neck. Cervical spine x-rays performed 11/03/11 reported soft tissue and osseous structures within normal limits. Progress note dated 11/17/11 indicated the claimant states neck is hurting her more. On examination there was tenderness and spasm in the neck left trapezius, and stiffness of the neck. Range of motion was restricted. There was no weakness, no abnormal reflexes, and no sensory changes to light touch and pin prick. Cervical compression test was negative. Diagnosis was cervical sprain. Patient was prescribed Ultram ER. MRI of the cervical spine was recommended.

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

This patient was injured on xx/xx/xx. She was referred for physical therapy. There is a single therapy note/evaluation dated 11/07/11, but no subsequent physical therapy progress reports were submitted for review documenting the total number of therapy visits completed for the cervical spine. Clinical examination revealed no evidence of weakness, sensory deficits, or

abnormal deep tendon reflexes in the upper extremities. Cervical compression test was negative. As such the reviewer finds the claimant does not meet medical necessity criteria specified in Official Disability Guidelines neck and upper back chapter as there is no documentation of failure of at least three months of conservative treatment, and no evidence of neurologic deficit on clinical exam or known cervical spine trauma. The reviewer finds there is not a medical necessity at this time for cervical MRI without contrast.

**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)