

# I-Decisions Inc.

An Independent Review Organization  
5501 A Balcones Drive #264  
Austin, TX 78731  
Phone: (512) 394-8504  
Fax: (207) 470-1032  
Email: manager@i-decisions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Dec/27/2011

**IRO CASE #:**

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

Cervical ESI 62310 77003 72275 62264

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

M.D., 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**

Official Disability Guidelines-Treatment for Workers' Compensation, Neck & Upper back  
Physical therapy and CPMP progress notes 09/01/09-09/30/10  
Operative report dated 03/03/10  
Clinic notes dated 01/25/11-10/21/11  
MRI cervical spine without contrast dated 05/12/11  
MRI thoracic spine without contrast dated 05/12/11  
Designated doctor evaluation amendment to report dated 08/31/11  
Denial Letters, 11/03/11, 11/30/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xx. On this date there was an explosion at the refinery and the patient fell on his right shoulder. Discharge summary dated 09/25/09 indicates that the patient completed 9 sessions of physical therapy. The patient underwent right shoulder arthroscopy with debridement of labral tearing and subacromial decompression on 03/03/10 followed by a course of physical therapy. The patient completed a chronic pain management program in 2010. Orthopedic report dated 04/28/11 indicates that the patient underwent designated doctor evaluation on 04/15/11. Extent of injury is listed as cervical sprain/strain and thoracic sprain/strain. MRI of the cervical spine dated 05/12/11 revealed 2 mm dorsal annular bulge C3-4 without loss of disc height; no neural compression. Designated doctor amended report dated 08/12/11 notes that the patient reached MMI as of 08/12/11 with 3% whole person impairment. Physical examination on 10/21/11 notes there is tenderness over the anterolateral aspect of the right shoulder with limited range of motion with abduction of approximately 170 degrees and near-complete internal and external rotation. There is tenderness on his right posterior cervical region with decreased range of motion with bilateral lateral bending and positive axial compression test. He had a mildly

positive Spurling sign reproducing symptoms in his right shoulder. Motor strength and sensation are intact in the upper extremities, and deep tendon reflexes are 2+ in the biceps, triceps and brachioradialis.

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

The patient's physical examination fails to establish the presence of active cervical radiculopathy, and the submitted MRI of the cervical spine does not support the diagnosis. The patient has been determined to have reached maximum medical improvement as of 08/12/11 by a designated doctor with 3% whole person impairment. The request is nonspecific and does not indicate which level/s is/are to be injected. The reviewer finds the requested cervical ESI 62310 77003 72275 62264 is not 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)