

Notice of Independent Review Decision

DATE OF REVIEW: 09/21/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical MRI w/o contrast

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

The TMF physician reviewer is board certified in anesthesia and pain management with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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 or not medical necessity exists for each of the health care services in dispute.

It is determined that the cervical MRI w/o contrast is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 09/05/12
- Letter from attorneys to TDI – 09/04/12
- Letter addressed to IRO from the injured worker – (date stamped) 08/17/12
- Adverse Determination Notice – 06/28/12
- Adverse Determination After Reconsideration Notice – 07/24/12
- Letter from attorneys to – 09/10/12
- Office visit notes – 03/02/12 to 08/20/12
- Request for prior authorization for cervical MRI – 06/23/12, 07/16/12
- Psych evaluation – 04/25/11
- Patient to Physician Office Telephone Messages – 05/20/11 to 07/09/12
- Operative report – 07/26/10

- Report of pre-operative clearance – 07/19/10
- Report of x-rays of the cervical spine – 08/10/10
- Report of MRI of the cervical spine – 10/20/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx resulting in injury to his cervical spine. He underwent surgery in the form of a cervical fusion with the implantation of a cervical stimulator which was later removed. The patient now has complaints of increased neck and left arm pain with decreased range of motion and he is wearing a neck brace. There is a request for the patient to undergo a cervical MRI without contrast.

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

The office visit notes of 07/16/12 indicate that the patient has left arm paralysis and this is not mentioned in the previous office visit notes. While this description is not precise, it does qualify as a progressive neurologic deficit and would meet the ODG guidelines for an MRI.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE
- 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)