True Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:
April/1/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Cervical Spine X Rays

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

Neurosurgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] 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 <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes 12/20/11 -02/28/13
CT scan cervical spine 01/05/11
CT myelogram 02/21/12
Previous utilization reviews 10/26/06 and 02/03/11
Previous IRO 03/18/13

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a female who reported an injury to her cervical spine. CT myelogram dated xxxxxx revealed mild spondylosis of the cervical spine. The patient previously underwent anterior cervical fusion at C5 through C7. Minimal encroachment was noted upon the thecal sac at C3-4 and C4-5. No significant stenosis was noted. Clinical note dated 02/27/12 detailed the patient complaining of cervical spine pain and bilateral trapezial pain. Upon exam, trigger points were noted in the upper trapezial area. Diminished reflexes were noted at the right biceps. The patient demonstrated 30 degrees of cervical flexion 25 degrees of extension and 10 degrees of bilateral lateral flexion. Clinical note dated 04/02/12 detailed the patient detailed the patient stating that the medication regimen of Percocet was effective. Clinical note dated 05/29/12 detailed the patient detailed the patient complaining of cervical spine pain with radiation into the left upper extremity down to the third and fourth digits. Pain was also radiating to the right third and fourth digits with numbness and tingling. Clinical note dated 07/17/12 detailed the patient rating her cervical spine pain as 8/10. The patient was

recommended for nerve blocks; however, no information was submitted regarding the outcome of the procedure. Clinical note dated 02/13/13 detailed the patient continuing with neck pain and trapezial region pain. IRO dated 03/18/13 for cervical x-ray resulted in a denial secondary to lack of significant exam findings indicating the need for cervical x-ray.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Clinical documentation provided for review notes the patient complaining of cervical spine pain despite previous surgical intervention. Cervical spine x-ray would be recommended by evidence based guidelines provided that the patient meets specific criteria, including significant trauma as well as significant findings indicating paresthesia and cervical tenderness. The patient previously underwent anterior cervical discectomy and fusion. However, no information was submitted regarding significant clinical changes that would warrant an x-ray of the cervical spine at this time. No significant changes were noted in the clinical presentation. No objective findings were noted in the cervical spine. Given the lack of significant clinical findings involving the cervical spine, this request is not indicated. As such, the clinical documentation provided for review does not support this request at this time.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)