

# Applied Resolutions LLC

An Independent Review Organization  
900 N. Walnut Creek Suite 100 PMB 290  
Mansfield, TX 76063  
Phone: (214) 329-9005  
Fax: (512) 853-4329  
Email: manager@applied-resolutions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Sep/17/2013

**IRO CASE #:**

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

1 Computed Tomography of Cervical Spine without Contrast

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

Board Certified PM&R; 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:**

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical note dated 07/26/13

Clinical note dated 08/13/13

Clinical note dated 09/03/13

Adverse determinations dated 08/08/13 & 08/27/13

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who reported an injury regarding her neck and upper back. The clinical note dated 07/26/13 details the patient stating that she had been in a motor vehicle accident when she was rear ended. The patient was noted to have presented to an urgent care facility where x-rays were completed. The patient rated her cervical region pain as 5/10 and located in the posterior portion of the neck. The patient described the pain as dull, aching spasms with pain upon range of motion. Upon exam, the patient was able to demonstrate full range of motion throughout the cervical spine. Tenderness was noted upon palpation at the paraspinal cervical muscles. The clinical note dated 08/13/13 mentions the patient having previously undergone conservative treatments where no improvement was noted. The patient continued with 5/10 pain. The clinical note dated 09/03/13 describes the patient continuing with a dull aching spasm with pain upon range of motion in the neck. The patient had no complaints of weakness. The pain was located at the back of the neck and both sides. Previous radiographs revealed possible degenerative joint disease to one of the cervical vertebrae. Normal reflexes, sensation, and strength were noted in the upper extremities. The patient was recommended for a CT scan of the cervical spine without contrast.

The previous utilization review dated 08/27/13 revealed an adverse determination for a CT

scan of the cervical spine secondary to no complaints of radiculopathy.

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

The documentation submitted for review elaborates the patient complaining of cervical region pain following a motor vehicle accident. A CT scan would be indicated provided the patient meets specific criteria to include the patient having specific neurologic deficits in the appropriate distributions. The patient was noted to have no specific complaints of paresthesia in the hands or feet. The patient was noted to have complaints of moderate levels of pain that were rated as 5/10. The clinical notes do mention the patient having previously undergone plain films with no significant findings indicating an acute injury. Given that no information was submitted confirming the patient's paresthesia, neurologic deficits, or plain films revealing positive findings, this request is not indicated. As such, it is the medical assessment of this reviewer that the request for a CT scan of the cervical spine without contrast is not recommended 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)