

Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jul/29/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical CT Mylogram

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

Board Certified Orthopedic Surgery

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 medical necessity exists for each health care service in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury to her neck. A clinical note dated 05/07/13 indicated the patient complaining of neck pain, right greater than left, radiating to the trapezius in between the shoulder blades. The patient also reported constant numbness and tingling. The patient rated the pain 8-9/10. A clinical note dated 03/26/14 indicated the patient complaining of worsening neck pain radiating to the right biceps. The patient described the pain as a constant dull ache. Numbness was identified in the hands. Generalized weakness was identified in bilateral arms. The patient rated the pain 2/10. The patient utilized Norco, Zanaflex, and Percocet. The MRI of the cervical spine dated 04/16/14 revealed degenerative changes at C5-6 and C6-7. Clinical note dated 04/25/14 indicated the patient continuing with 2/10 neck pain. Flexion and rotation of the neck exacerbated the pain. No numbness or weakness were identified in the upper extremities. A clinical note dated 05/29/14 indicated the patient complaining of constant pain in the upper back and neck. Upon exam the patient demonstrated approximately 50% of normal range of motion throughout the neck in all area in all ranges. The patient underwent extensive conservative treatment in the past addressing the cervical complaints.

The Utilization reviews dated 06/03/14 and 06/06/14 resulted in denial as no neurological deficits were identified in the upper extremities.

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

The request for CT myelogram of the cervical spine is non-certified. The clinical documentation indicates the patient complaining of neck pain. The patient experienced some generalized weakness in the upper extremities. However, more recent clinical notes indicate the patient demonstrating no neurological deficits. No weakness, reflex, or sensation deficits were identified by clinical exam. Neurological deficits identified by exam this request is not indicated. As such, it is the opinion of this reviewer that the request for CT myelogram of the cervical spine 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)