

C-IRO Inc.

An Independent Review Organization

1108 Lavaca, Suite 110-485

Austin, TX 78701

Phone: (512) 772-4390

Fax: (512) 519-7098

Email: resolutions.manager@ciro-site.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/21/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: MRI Cervical

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., 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. It is the opinion of this reviewer that the request for MRI Cervical is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical note dated 11/04/13

Clinical note dated 07/02/13

Clinical note dated 08/13/13

Clinical note dated 09/24/13

Clinical note dated 10/03/13

Clinical note dated 10/31/13

Clinical note dated 11/14/13

Clinical note dated 12/24/13

Clinical note dated 01/21/14

Clinical note dated 02/18/14

Clinical note dated 03/18/14

Clinical note dated 04/15/14

Clinical note dated 05/20/14

Clinical note dated 05/27/14

Clinical note dated 06/09/14

Arthrogram of the right hip dated 11/28/12

Functional capacity evaluation dated 10/08/13

MR arthrogram of the right shoulder dated 10/17/13

RME dated 12/20/13

Psychological diagnostic interview dated 01/09/14

Psychological testing and diagnostic interview dated 02/06/14

MRI of the right hip dated 02/10/14

Utilization reviews dated 01/14/14 & 02/26/14

Adverse determinations dated 06/02/14 & 06/17/14

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who reported an injury to her cervical region. The clinical note dated 11/04/14 indicates the patient complaining of neck and right shoulder pain as a result of a trip. The patient has been indicated as working at the time. The patient reported immediate pain in her knees, face, neck, and right shoulder. There is an indication the patient has previously undergone physical therapy for 1 month. An MRI of the hip revealed a tear. The patient underwent a right hip labral repair followed by 24 postoperative physical therapy sessions which did provide some benefit. The patient reported ongoing right shoulder and neck pain that was described as constant. The patient rated the pain as 7/10. Upon exam, the patient was able to demonstrate 50 degrees of cervical flexion, 10 degrees of extension, along with 15 degrees of left lateral flexion, and 10 degrees of right lateral flexion, 50 degrees of right rotation, and 60 degrees of left rotation. The clinical note dated 09/24/13 indicates the patient having undergone a total of 3 operative procedures at the right hip. The patient had completed an initial course of 12 physical therapy visits and was initiating a 2nd set of 12 sessions. The patient rated her ongoing pain as 1/10. The MR arthrogram of the right shoulder dated 10/17/13 revealed a severe supraspinatus tendinopathy at the distal 1.5cm of the tendon without a partial or full thickness tear. Mild AC joint hypertrophy was identified with inferior osteophytic spurring impinging the supraspinatus. No other significant findings were identified. The required medical examination dated 12/20/13 indicates the patient able to demonstrate 40 degrees of right shoulder extension, 150 degrees of flexion, 150 degrees of abduction, 40 degrees of adduction, and 80 degrees of internal rotation. Diffused tenderness was identified throughout the right shoulder. The clinical note dated 12/24/13 indicates the patient complaining of radiating pain into the right upper extremity. The patient rated the pain as 9/10. The note indicates the patient utilizing Flexeril, Relafen, Tramadol, Tylenol, and Lidoderm patches. The clinical note dated 05/27/14 indicates the patient being recommended for an MRI of the cervical spine. The clinical note dated 06/09/14 indicates the patient being recommended for physical therapy for the bilateral knee complaints.

The utilization review dated 06/02/14 resulted in a denial for an MRI of the cervical spine as no information had been submitted regarding the patient's radiculopathy. No information had been submitted regarding any progressive neurologic deficits.

The utilization review dated 06/17/14 resulted in a denial for an MRI of the cervical spine as no objective evidence had been submitted supporting any neurologic deficits.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient complaining of cervical region pain. An MRI of the cervical spine is indicated for patients who have demonstrated significant neurologic deficits. No information was submitted regarding the patient's development of significant neurologic deficits manifested by strength, reflex, or sensation deficits. Without this information in place, it is unclear how the patient would benefit from a cervical MRI. As such, it is the opinion of this reviewer that the request for MRI Cervical 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)