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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/17/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: MRI of the cervical spine

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Orthopedic Surgery

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. It is the opinion of this reviewer that the request for an MRI of the cervical spine is not indicated as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a xx year old who reported injuries to his left shoulder and neck after lifting a 90 lb. bag of cement. The initial incident occurred on xx/xx/xx. The clinical note dated 02/11/15 indicates the patient having initially been put on light duty with a lifting and pulling restriction. However, the patient was unable to be accommodated for this. The patient reported stiffness at the left side of the neck as well as 10/10 pain at the neck and left shoulder. The clinical note dated 05/05/15 indicates the patient continuing with cervical and left shoulder pain. Upon exam, the patient's pulses in the upper extremities were equal and intact. Reflexes were identified as within normal limits. Tenderness continued over the shoulder blade on the left. Muscle spasms were identified in the cervical spine and between the shoulder blades. The note indicates the patient having a positive Spurling's compression test. Decreased range of motion was identified throughout the cervical spine. The therapy note dated 02/20/15 indicates the patient having undergone 4 physical therapy sessions to date. The clinical note dated 05/15/15 indicates the patient continuing with ongoing neck pain. The note indicates the patient utilizing Ultracet, Zanaflex, Celebrex as well as the use of a Medrol dose pack. The note indicates the patient able to demonstrate 5/5 strength throughout the upper extremities. The note indicates the patient having a negative Spurling's sign as well as a negative Lhermitte's sign. Pain was elicited with range of motion testing throughout the cervical spine. X-rays of the cervical spine revealed no narrowing of the disc space. The clinical note dated 06/12/15 indicates the patient continuing with cervical pain. Radiating pain was identified from the neck into the left shoulder. The patient has been recommended for an MRI of the cervical spine.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient complaining of ongoing cervical region pain with radiating pain to the left shoulder. An MRI of the cervical spine is indicated for patients with chronic neck pain where radiographs show essentially normal findings and the patient has been identified as having neurologic signs or symptoms or the patient continues with complaints of findings consistent with radiculopathy that are severe or progressive in nature. No information was submitted regarding the patient's 3 month completion of a course of conservative treatments. There is an indication the patient had undergone radiograph studies of the cervical region which revealed essentially normal findings. No information was submitted regarding the patient's neurologic deficits or findings consistent with radiculopathy. Given these factors, the request is not indicated as medically necessary. As such, it is the opinion of this reviewer that the request for an MRI of the cervical spine is not indicated as medically necessary and the prior denials are upheld.

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)