

IRO Express Inc.

An Independent Review Organization

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Notice of Independent Review Decision ***IRO Express Inc.***

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Cervical spine MRI without contrast

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)

Patient Clinical History (Summary)

The patient is a female who reported injuries to her neck and right shoulder as a result of pulling on a pallet jack at work. The clinical note dated xx/xx/xx indicates the patient primarily focused on the right shoulder pain. The note indicates the patient utilizing Motrin for ongoing pain relief. The x-rays of the right shoulder dated xx/xx/xx revealed essentially normal findings. The MRI of the right shoulder dated xxx revealed bursitis at the subacromial and subdeltoid space as well as tendinosis at the supraspinatus and infraspinatus. The clinical note dated xxxx indicates the patient continuing with right shoulder pain. There is an indication the patient had radiating pain into the right hand as well. There is an indication the patient had undergone x-rays of the cervical spine which revealed calcification at the anterior longitudinal ligament with narrowing at C6 and C7. The clinical note dated xxxx indicates the patient continuing with cervical region pain. Radiating pain continued along the right upper extremity to the hand. There is an indication the patient undergone physical therapy. The note indicates the therapy was focused on the right shoulder complaints. The utilization reviews dated xxx and xxxxx resulted in denials for an MRI of the cervical spine as no information was submitted regarding the patient's completion of any conservative treatments addressing the cervical complaints.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The documentation indicates the patient complaining of right shoulder and neck pain. An MRI of the cervical spine is indicated provided that the patient meets specific criteria including completion of all conservative therapies. There is an indication the patient had undergone physical therapy. However, the clinical notes indicate the therapy was focused on the right shoulder complaints. Given that no information was submitted regarding the patient's previous involvement with any therapeutic interventions focused on the cervical complaints, the request is not indicated. As such, it is the opinion of this reviewer that the request for a cervical spine MRI without contrast is not indicated 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 and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)