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Notice of Independent Review Decision

Case Number:

Date of Notice: 02/17/2016

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:

MRI Cervical Spine 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 male who reported an injury on XX/XX/XX. He was diagnosed with low back pain and neck pain. The clinic note dated XX/XX/XX indicated the patient complained of tenderness in the neck and low back. The physical exam of the cervical spine revealed tenderness on palpation of the paravertebral musculature bilaterally worse on the left side in both medial and scapular border areas, and range of motion was limited by 25% by pain in all directions. Motor and sensory reflexes were bilaterally symmetrical and intact. X-rays of the cervical spine did not show presence of any recent fracture or dislocation. The patient was placed on physical therapy. The clinic note dated XX/XX/XX indicated the patient was placed on medication for pain. The physical therapy followup evaluation of the cervical spine completed on XX/XX/XX indicated the patient had mild spasm over the upper trapezius and range of motion was in within normal limits. The patient's muscle strength had remained the same. The evaluation indicated the patient has reached all goals.

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

The Official Disability Guidelines recommend an MRI of the cervical spine with chronic neck pain after 3 months of conservative treatment, normal radiographs, and neurologic signs or symptoms present. The documentation submitted for review failed to indicate failure of conservative treatment for at least 3 months and neurological signs or symptoms present. The documentation failed to indicate a rationale for cervical MRI as the patient's symptoms were resolving. As such, the previous determination is upheld.

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)