

Independent Resolutions Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: (682) 238-4977

Fax: (888) 299-0415

Email: carol@independentresolutions.com

Date: 2/12/2018 1:26:16 PM CST

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: MRI of the cervical spine w/o contrast

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

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- | | |
|---|--------------------------------|
| <input type="checkbox"/> Overturned | Disagree |
| <input type="checkbox"/> Partially Overturned | Agree in part/Disagree in part |
| <input checked="" type="checkbox"/> Upheld | Agree |

PATIENT CLINICAL HISTORY [SUMMARY]: This case involves a now XXXX with history of an occupational claim from XXXX. The mechanism of injury is detailed as a XXXX. The current diagnosis is cervicalgia. The previous treatments were detailed to include epidural steroid injection, MRI, medications, and office visits. The patient was seen XXXX for complaint of posterior cervical gripping pain that radiated into the trapezius muscle that the patient rated as 6/10 on a pain scale. Physical examination revealed tenderness to the cervical paravertebral musculature, painful cervical range of motion, normal muscle strength of the bilateral upper extremities, 3/4 deep tendon reflex of the left upper extremity, decreased sensation at the left upper extremity in the C5 through C8 dermatomes, and positive Hoffmann sign on the left.

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

The Official Disability Guidelines recommend MRI of the cervical spine after the trial and failure of 3 months of conservative treatment and normal radiograph findings. In this case, the documentation provided evidence of continued complaints of cervical pain that radiated into the trapezius muscle. Physical examination revealed decreased range of motion of the cervical spine, normal strength, decreased sensation at the left upper extremity in the C5 through C8 dermatomes, and positive Hoffmann sign on the left. However, the supplied documentation failed to provide evidence of at least 3 months of conservative treatment prior to the request for MRI. Furthermore, the documentation failed to include evidence of normal radiographs. As such, the request for MRI of the cervical spine without contrast is not medically necessary.

As such, the prior determination is upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Neck& Upper Back, Magnetic resonance imaging (MRI)