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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/31/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI lumbar spine

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

M.D., Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Low Back, Indications for Imaging

Functional Capacity Evaluation: 02/13/08

Dr.: 01/13/10, 08/02/10, 09/13/10, 10/25/10, 01/03/11, 02/11/11, 02/28/11

Peer Review: 02/18/11, 03/08/11

Operative Reports: 09/11/07, 11/25/08, 11/03/09, 03/30/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a XX year-old male who sustained a work related injury to his lower back on XX/XX/XXXX. When the claimant saw Dr. on 02/14/XX he complained of paresthesias down his left lower extremity to foot. On examination he had some evidence of numbness and decreased sensation distally although he was neurovascularly intact on gross exam. Dr. recommended an MRI. This was noncertified in a Peer Review dated 02/18/11, as the records mentioned the claimant had 2 epidural steroid injections, which implied that he had had an MRI done. There were also no defined signs of radiculopathy. When the claimant saw Dr. on 02/28/11, he reported that he had never had an MRI as it was denied by insurance. He complained that his back pain was worse and he now had numbness to his lower leg and foot with increased weakness. He also complained of transient paresthesias in his toes. On examination the claimant had decreased strength in his left leg but his deep tendon reflexes of his bilateral lower extremities were grossly equal. Dr. again recommended an MRI. This was noncertified in a peer review dated 03/08/11 as there was no specific weakness documented or muscle testing performed and there was no radicular pattern tingling or numbness documented.

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

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld per Official Disability Guidelines.

There is no radicular distribution described, no progressive neurologic deficit, no motor weakness, no decreased sensation in a dermatomal distribution. It is not clear the patient has recently exhausted conservative care to include physical therapy, stretching, strengthening, range of motion modalities, oral anti-inflammatory agents, possibly an oral steroid preparation as tolerated, or pain medications. Similarly, it appears the patient recently had epidural steroid injections. It is unclear what the response to them was or at what levels they were done or whether an MRI was done prior to those procedures. For these reasons, the reviewer finds no medical necessity for MRI lumbar spine.

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)