

# US Resolutions Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Apr/17/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Lumbar MRI w/enhancement, Flexion/extension xrays, EMG/ NCV lower extremities

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

**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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.**

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical notes 09/13/11-02/26/13

Prior reviews 02/19/13 and 03/12/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female who was initially injured on xx/xx/xx. The patient was followed for chronic low back pain radiating to the lower extremities on the right worse than the left. As of 09/11, the patient had decreased sensation in the L5 nerve root distribution to the right on physical examination. Straight leg raise signs were reported as positive at 40 degrees. The patient was continued on Lortab for pain. The patient reported control of pain with the use of Lortab and follow up on 01/10/13 stated that the patient felt that her lower extremity pain was becoming worse over time. Physical examination identified decreased reflexes at the ankles with decreased sensation in the nerve roots and L5-S1 nerve roots and L5-S1 dermatomes bilaterally. Straight leg raise signs were reported as positive bilaterally. The patient was recommended for updated MRI of the lumbar spine with radiographs including flexion extension views and EMG/NCV studies of the lower extremities. Follow up on 02/26/13 reported the inability to examine the left lower extremity secondary to pain. Continued loss of sensation in the right L5-S1 nerve roots and loss of reflexes in the lower extremities were noted. The request for updated MRI studies flexion extension radiographs and electro-diagnostic studies was denied by utilization review on 02/19/13 as there was no indication of any new neurological changes or documentation to express concern with instability of the lumbar spine. The request was again denied by utilization review on 03/12/13 as there was no clear change or progression of neurological findings and there was no concern for instability in the lumbar spine. There was also no indication for a nerve conduction study.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient has had ongoing complaints of chronic low back pain radiating to the lower extremities. The patient felt that her symptoms were worsening over times; however, exam findings did not reveal a clear progressive or severe neurological deficit to warrant updated imaging studies of the lumbar spine including MRI and radiographs. No prior imaging studies were submitted for review and given the lack of any significant changes on multiple physical examinations, no additional imaging or electro-diagnostic studies would be warranted as medically necessary at this time per guideline recommendations. Additionally, there is no indication from the clinical documentation that any suspected instability is present in the lumbar spine that would require updated radiograph studies.

Given the absence of any clear progressive or severe neurological deficit on physical examination, it is the opinion of this reviewer that the requested Lumbar MRI w/enhancement, Flexion/extension xrays, EMG/ NCV lower extremities would not be supported as reasonable and necessary at this time 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

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)