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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jan/24/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI Spinal Canal Lumbar w/o Contrast Material

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

Board Certified Orthopedic 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

Texas outpatient non-authorization recommendation 11/30/12

Texas outpatient reconsideration decision: non-authorization 12/26/12

Pre-authorization request and reconsideration request

Office notes MD 03/28/11-12/04/12

MRI lumbar spine 03/09/11

Procedure notes bilateral L4-5, L5-S1 facet injections 06/23/11

Procedure note left L5-S1 transforaminal epidural steroid injection, left S1 selective nerve root injection 06/12/11

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who slipped and fell backwards on xx/xx/xx and developed immediate acute low back pain. MRI of the lumbar spine dated 03/06/11 revealed L5-S1 disc herniation; L4-5 mild right neural foraminal narrowing. The claimant presented with complaints of low back pain radiating to the left lower extremity. He was treated conservatively with physical

therapy, chiropractic, transforaminal epidural steroid injection, facet block, and medications. The claimant was seen on 11/05/12 having last been seen in 10/11. The claimant was recommended to undergo lumbar MRI to evaluate the spinal and surrounding tissues.

Non-authorization of the proposed lumbar spine MRI was recommended on 11/30/12, noting that physical examination revealed greater ease with standing from a seated position. Lumbar spine had guarded motion with mild exacerbation on extension. Lower extremities were neuromuscularly intact; however, exam noted a positive straight leg raise as well as diminished left patellar and Achilles reflex. It was noted that repeat MRI was not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. As the claimant appeared to be improving both subjectively and objectively, medical necessity of repeat MRI was not supported.

A reconsideration request for lumbar MRI was non-authorized per determination dated 12/26/12, noting that there was no clinical documentation of any significant progressive neurological symptoms supporting the need for repeat MRI. It was noted that lower extremity pain was improved as well as functional mobility and that medical necessity of lumbar MRI was not established.

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

The claimant sustained an injury to the low back secondary to a slip and fall on xx/xx/xx. He complained of low back pain radiating to the left lower extremity. The most recent progress notes reflect that the claimant has improved. There was no evidence of progression of neurological deficits on clinical examination. Official Disability Guidelines provide that repeat MRI is not routinely recommended and should be reserved for significant change in symptoms and/or findings suggestive of significant pathology. As noted above, there was no evidence of progressive neurological deficit or significant change in symptomatology that would warrant repeat MRI of the lumbar spine. As such, it is the opinion of this reviewer that the request for MRI of the lumbar spine is not supported as medically necessary.

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

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES