

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Dec/31/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Outpatient lumbar MRI

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D. Board Certified Neurosurgery

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. It is the opinion of the reviewer that medical necessity is not established for the outpatient lumbar MRI

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical notes Dr. dated 04/09/12-08/21/12

Clinical note Dr. dated 11/07/12

MRI lumbar spine dated 04/23/12

Electrodiagnostic studies dated 05/22/12

Employer's first report of injury or illness dated xx/xx/xx

Letter from patient undated

Appeal letter Dr. dated 11/21/12

Prior review dated 11/14/12 and 12/07/12

PATIENT CLINICAL HISTORY [SUMMARY]: The claimant is a male who sustained an injury on xx/xx/x when he slipped and fell. The patient developed complaints of low back pain radiating into right lower extremity, and clinical evaluation on 04/09/12 by Dr. revealed decreased sensation in lateral aspect of right calf with slight weakness in the right EHL. MRI studies of lumbar spine completed on 04/23/12 revealed a 1 mm bulge at L4-5 and 6 mm right paracentral disc extrusion at L5-S1 extending 8 mm below the disc level causing displacement of right S1 nerve root posteriorly. Electrodiagnostic studies revealed an absence H-Reflex to the right consistent with right S1 radiculopathy. Subsequent evaluation by Dr. revealed loss of right Achilles reflex. The patient was evaluated by Dr. on 11/07/12 for continuing complaints of low back pain radiating to right lower extremity. Physical examination at this visit revealed weakness on right toe flexion. The patient had absent right Achilles reflex. The patient was recommended for surgical intervention prior to an updated

MRI study to confirm no significant anatomical changes.

The request for an outpatient repeat MRI of lumbar spine was denied by utilization review on 11/14/12 as there was no evidence of significant new neurological findings to support repeat studies.

The request was again denied by utilization review on 12/07/12 as clinical findings were not consistent with surgical lesion.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient's physical examination findings are consistent with large disc extrusion noted on 04/12 MRI studies which revealed displacement of right S1 nerve root. The patient's physical examination findings did not reveal any significant new or progressively worse exam changes that would reasonably support updated imaging. Per current evidence based guidelines repeat MRI studies are recommended only when there is evidence of new or progressively severe neurological deficit. As the clinical documentation submitted for review does not meet guideline recommendations for the requested services, it is the opinion of the reviewer that medical necessity is not established for the outpatient lumbar MRI, and 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)