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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/03/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: MRI Thoracic spine without contrast

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

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 the request MRI Thoracic spine without contrast is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Adverse determination letter 05/01/13
Pre-authorization determination letter 05/31/13
Appeal letter MRI 05/31/13
Office note 05/09/13
Office notes 04/22/13-05/31/13
employee injury and treatment form 04/18/13
Department of Insurance form DWC-041 04/23/13
Functional capacity evaluation 06/14/13
Lumbar spine MRI 06/12/13
X-rays lumbar spine 06/12/13
Thoracic spine x-rays 06/12/13
Pre-authorization request form 04/26/13
Scheduling form 04/23/13
Pre-authorization request form 05/14/13
SOAP notes 05/03/13 and 05/01/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who sustained a lifting injury to the low back on xx/xx/xx. She complained of low back pain associated with radiation down both legs. X-rays of the lumbar spine revealed transitional lumbosacral vertebrae; otherwise unremarkable study. X-rays of the thoracic spine on 06/12/13 were reported as a normal study. MRI of the lumbar spine dated 06/12/13 revealed lumbosacral transitional vertebrae with a lumbarized S1; L5-transitional S1 focal disc herniation and annular tear. Records indicated that the patient had been treated conservatively with physical therapy and activity modification/light duty. It was noted that the claimant had little improvement with

physical therapy. There was documented left leg weakness which was reflective of lumbar radiculopathy.

A request for lumbar MRI without contrast and MRI of the thoracic spine without contrast was non-certified per review dated 05/01/13. The reviewer noted that there was no evidence of neurological deficit on exam, and physical therapy had not been initiated. Consequently the claimant does not meet Official Disability Guidelines criteria.

A reconsideration request for MRI of the lumbar spine without contrast and MRI of the thoracic spine with contrast was partially authorized. The reviewer determined that MRI of the lumbar spine was authorized as medically necessary noting that the claimant had evidence of lumbar radiculopathy with failure to improve with conservative care. Consequently partial certification of lumbar MRI was indicated; however, medical necessity was not established for MRI of the thoracic spine.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The claimant is noted to have sustained an injury on xx/xx/xx secondary to lifting heavy boxes. She felt a sharp pain in her back radiating to both legs. Per appeal letter dated 05/31/13 the claimant has attended 12 sessions of physical therapy and her condition has failed to improve. She needs further imaging studies to determine the source of her pain and expand her treatment options. Based on the clinical information provided, it is the opinion of this reviewer that medical necessity is not established for MRI of the thoracic spine without contrast. The claimant has specific findings indicative of lumbar radiculopathy, and MRI of the lumbar spine was authorized. This study revealed L5-transitional S1 focal disc herniation with annular tear with narrowing of the canal to 8mm AP. There was also right greater than left lateral recess encroachment. These findings appeared consistent with physical examination findings. Plain radiographs of the thoracic spine were reported as normal study. Given the lack of findings indicative of significant thoracic spine pathology, it is the opinion of the reviewer that the request MRI Thoracic spine without contrast is not recommended as medically necessary.

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)