

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Apr/24/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI

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

Board Certified Neurosurgeon

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 records Rehabilitation 05/03/12-10/18/12

Physical performance evaluation 10/09/12

Clinical record Dr. 07/31/12

Prior reviews 03/05/13 and 03/29/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who initially sustained an injury on xx/xx/xx when he was hit in the head and neck region. No specific mechanism of injury was noted, but the patient was diagnosed with post-concussive syndrome. It appeared that the patient was status post a cervical fusion around 01/11. It appeared that the patient also had a spinal cord stimulator trial at some point in time. The patient was noted to have completed and attended a chronic pain management program through 10/12. The only clinical record from Dr. was from 07/31/12 which identified hypoactive reflexes in the lower extremities with paresthesia in an L5 and S1 nerve root distribution to the left. There were recommendations for an MRI of the lumbar

spine at this visit. No further evaluations from Dr. were provided. The request for an MRI of the lumbar spine was denied by utilization review on 03/05/13 as there were no objective neurological deficits requiring MRI. There was no documentation regarding conservative treatment. The request was again denied by utilization review on 03/29/13 as there was no updated clinical evidence for neurological deficits supporting the request.

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

The clinical documentation established that the patient had low back complaints as of 07/12. On the 07/12 physical examination by Dr., there was evidence of paresthesia in a left nerve root distribution with hypoactive reflexes. No clear motor weakness was identified and there was weakness of the gastrocnemius on the left. No prior imaging of the lumbar spine was noted and there are no updated physical examination findings by Dr. establishing that the patient had any progressive or severe neurological deficits that would now support MRI studies of the lumbar spine. Given that the patient has completed a chronic pain management program since being evaluated by Dr., it is unclear at this time what further clinical treatment could be provided to the patient that would address a chronic pain condition that has already been attended and addressed with a tertiary chronic pain management program. Given the insufficient clinical documentation submitted for review supporting MRI studies of the lumbar spine, it is the opinion of this reviewer that the prior denial of medical necessity is established and 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)