

US Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

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

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: MRI Lumbar 72148

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. It is the opinion of this reviewer that the request for a MRI Lumbar 72148 is recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

MRI of the lumbar spine dated 03/21/11

Left shoulder arthrogram dated 03/22/12

Clinical notes dated 08/09/12 – 04/15/13

Previous utilization reviews dated 02/21/13 & 04/01/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his low back when he was lifting a heavy object. The MRI of the lumbar spine dated 03/21/11 revealed a left paracentral disc extrusion with a diffused disc bulge at L5-S1. Degenerative changes were also noted with mild bilateral neural foraminal narrowing. Mild bilateral L4-5 neural foraminal narrowing was also noted. Annular bulges were also noted at L2-3 & L3-4. The clinical note dated 02/08/13 details the patient complaining of low back pain. The patient described the pain as an electrical sensation that was noted to be sharp in nature. Radiation pain was noted into the left lower extremity along with posterior lateral thigh and calf. Intermittent radiation of pain was also noted to the left foot and ankle. Numbness was also noted as well. The note does detail the patient having previously undergone physical therapy with no significant benefit. The patient rated the pain as 10/10. The note further details the patient utilizing Hydrocodone, Flexeril, and Medrol dose pack for ongoing pain relief. The note does detail the patient able to demonstrate 4+/5 strength in the anterior tibialis, and 4/5 strength at the EHL, gastrocnemius, and hamstring muscles. Hypoesthesia was noted over the L5 & S1 distributions on the left. The clinical note dated 04/15/13 details the patient continuing with strength deficits noted in the lower extremities.

The previous utilization review dated 02/21/13 for an MRI of the lumbar spine resulted in a denial secondary to a lack of physical examination findings that would warrant a repeat MRI of the lumbar spine.

The previous utilization review dated 04/01/13 for an MRI of the lumbar spine resulted in a denial secondary to a lack of significant changes involving the patient's pathology.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation details the patient demonstrating strength deficits in the lower extremities specifically at the anterior tibialis and EHL. Documentation does detail the patient having previously undergone an MRI of the lumbar spine in 2011. Given the significant changes involving the patient's strength deficits noted in the lower extremities, and taking into account the time frame involved with the previous MRI, this request is reasonable. As such, it is the opinion of this reviewer that the request for a MRI Lumbar 72148 is 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)