

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: May/21/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: lumbar MRI w/o contrast

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

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 medical necessity is not established for the requested lumbar MRI w/o contrast at this time

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical record 09/10/12 and 03/11/13
Prior reviews 03/19/13 and 04/18/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who initially sustained an injury on xx/xx/xx. The patient was seen by on 09/10/12 with ongoing complaints of low back pain radiating to the lower extremities bilaterally. The patient had three prior fusions; however, no operative reports were submitted for review. Medications included muscle relaxants and anti-inflammatories. Physical examination demonstrated tenderness bilaterally over the paravertebral musculature with painful range of motion. No neurological deficits were identified. The patient was recommended to follow up within six months and continued on medications. A gap in clinical treatment was noted and the next clinical record was dated 03/11/13. The patient reported difficulty sleeping secondary to ongoing low back pain. The patient denied any lower extremity weakness. Physical examination demonstrated normal straight leg raise. There was some mild left psoas weakness with no reflex changes or sensory deficits. Radiographs of the lumbar spine showed prior fusion from L3 to L5. There was spondylosis at L2-3. The patient was recommended for an updated MRI of the lumbar spine secondary to low back pain and groin pain. The request for a new MRI of the lumbar spine without contrast was denied by utilization review on 03/19/13 as there was no evidence of significant change in symptoms or clinical findings indicative of significant pathology. The request was again denied by utilization review on 04/18/13 as there was no evidence regarding a significant change in neurological findings that would support repeat MRI studies.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has had ongoing complaints of low back and radiating lower extremity pain following three prior lumbar fusions from L3 to L5. The most recent clinical record indicated that presence of spondylosis at L2-3; however, there was no indication of any instability or possible canal or neural foraminal stenosis. The exam findings were relatively unremarkable with no significant progressive or severe neurological deficits that would reasonably warrant MRI studies of the lumbar spine at this time. As there is no evidence of a progressive or severe neurological deficit, the patient would not meet guideline recommendations regarding repeat MRI studies. Additionally given the prior lumbar fusion at L4-5 and L3-4 there is and would be an expected amount of artifacts from hardware placed at these levels that would limit the effectiveness of MRI to evaluate the L2-3 level. As the clinical documentation submitted for review does not meet guideline recommendations for the requested service it is the opinion of this reviewer that medical necessity is not established for the requested lumbar MRI w/o contrast at this time 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)