

True Resolutions Inc.

An Independent Review Organization

500 E. 4th St., PMB 352

Austin, TX 78701

Phone: (214) 717-4260

Fax: (214) 276-1904

Email: rm@trueresolutionsinc.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jul/06/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar MRI without contrast to include CPT code 72148

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

M.D. Board Certified Orthopedic 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical record 01/28/14

Clinical record 03/04/14

Clinical record 03/18/14

Clinical record 04/16/14

Utilization reviews 04/24/14 and 05/01/14

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an injury on xx/xx/xx when she slipped and fell. The patient was followed for complaints of neck pain and low back pain. Noted treatment included anti-inflammatories muscle relaxants and analgesics. The patient utilized Effexor. The patient described mild low back pain and bilateral thigh pain right worse than left that was moderate to severe. The patient reported some improvement with medications. There was a side effect reported with Mobic. The clinical records did not identify any specific neurological deficit. It was unclear whether the patient had been seen by physical therapy. The patient was referred for orthopedic consult which was done on 04/16/14. The patient described progressive complaints of low back pain with difficulty sitting standing lying down or rising from a chair. Physical examination findings noted a normal gait pattern. Tenderness to palpation of the paraspinal musculature was identified. No Waddell signs were apparent. Sensation to touch was normal in the upper extremities and lower extremities. Reflexes were 2+ and symmetric. There was full range of motion in the lumbar spine. No evidence of motor weakness was identified. Radiographs of the lumbar spine showed disc space narrowing at

L4-5 with grade 1 spondylolisthesis at L4-5. Dynamic instability was described. No independent radiology reports were available for review. The requested non-contrast MRI was denied by utilization review on 04/24/14 as there was no evidence for acute injury on radiographs and no reported neurological deficit or red flag findings. The request was again denied by utilization review on 05/01/14 as there was no evidence of trauma in a normal neurological examination.

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

The patient has been followed for continuing complaints of low back pain that had not improved with the use of medications including anti-inflammatories muscle relaxers or analgesics. There was no clinical documentation of any physical therapy for the patient. Per guidelines advanced imaging studies such as MRI are not recommended initially and there should be clinical documentation of failure of conservative treatment. The clinical documentation submitted for review did not clearly identify that the patient had failed a reasonable course of conservative treatment prior to the recommendation for MRI. Physical examination findings were unremarkable for any clear neurological deficit. No motor weakness reflex changes or sensory deficits were noted on physical examination. The patient did not present with any of the red flag findings. Radiographs from radiographs were reported to show dynamic instability at L4-5 however no independent radiology reports were available for review. Given the insufficient objective evidence regarding a progressive neurologic progressive or severe neurological deficit, and as there was limited clinical documentation regarding failure of appropriate course of conservative treatment, it is the opinion of this reviewer that medical necessity for the request is not established. As such the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES