

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Feb/18/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: MRI lumbar spine, (spinal canal and contents); without contrast material

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgery with Fellowship Training in Spine 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 the reviewer that the request for an MRI lumbar spine, (spinal canal and contents); without contrast material is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Letter of appeal dated 01/13/14
Adverse determinations dated 09/14/13 & 11/19/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who reported an injury regarding her low back from an unknown origin. The letter of appeal dated xxxxx indicates the patient complaining of low back pain with associated hip, leg, and feet pain. The patient stated that she was having difficulty with sleepless nights secondary to the pain. The note does mention the patient having undergone the use of pharmacological interventions addressing the low back pain. The note does mention the patient having previously undergone an MRI which revealed significant findings at the L4-5 level. The note further mentions the patient having undergone injection therapy.

The utilization review dated xxxxx resulted in a denial as no information was submitted regarding the patient having undergone a 6 week trial of clinical care with a subsequent reevaluation; and no significant findings of motor weakness, severe pain, or a recent malignancy or infection were noted.

The utilization review dated 11/19/13 resulted in a denial for an MRI of the lumbar spine as no new information was submitted confirming the need for imaging studies.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation submitted for review elaborates the patient complaining of low back pain. An MRI of the lumbar spine would be

indicated provided the patient meets specific criteria to include completion of a 6 week trial of conservative care with a subsequent reevaluation or the patient is noted to have significant findings including severe motor weakness, progressive pain, malignancy, infection, cauda equina syndrome, or a surgical procedure is planned for the patient. No information was submitted regarding the patient having completed a 6 week trial of physician guided conservative therapies. Additionally, no information was submitted regarding any findings that would indicate the apparent benefit for a surgical procedure without conservative treatments. Additionally, no malignancy or findings of cauda equina syndrome were noted in the documentation. Given these findings, the request is not indicated. As such, it is the opinion of the reviewer that the request for an MRI lumbar spine, (spinal canal and contents); without contrast material 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)