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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/04/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: MRI of Lumbar Spine with and without contrast

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, 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. It is the opinion of this reviewer that the request for an MRI of the lumbar spine with and without contrast is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his low back. The initial injury occurred on xx/xx/xx; however, a description of the initial injury was not provided. The clinical note dated 11/29/01 indicates the patient complaining of low back pain. Patient reported ongoing back pain with radiation pain to the left lower extremity. The note indicates the patient was neurologically intact at that time. The clinical note dated 04/01/14 indicates the patient having undergone a lumbar fusion at the L5-S1 level in May of 2003. The note indicates the patient having initially done well post-operatively. The patient also underwent an ACDF at the C5 through C7 levels in 2006 with significant benefit. However, the patient reported severe shooting pain in the back when lifting a small object. Radiating pain was identified to left buttocks and posterior thigh at that time. The patient reported difficulty with standing and walking at that time. The note indicates the patient utilizing tramadol for pain relief. The MRI of the lumbar spine dated 04/10/14 revealed previous L5-S1 fusion. Moderate to severe degenerative stenosis was identified L4-5 which was produced by a diffuse annular disc bulge and prominent facet and ligamentous hypertrophy. Severe degenerative changes were identified at the facets, bilaterally. The procedure note dated 06/24/14 indicates the patient undergoing a left sided L4-5 epidural injection. The clinical note dated 07/15/15 indicates the patient continuing with low back pain. The patient reported difficulty with standing and walking for prolonged period of time. The epidural injection provided some relief for short period of time. The clinical note dated 09/09/14 the clinical note dated 05/19/15 indicates the patient complaining of numbness and tingling in the buttocks and legs. The patient reported the symptoms were worse at night. The note indicates the patient being recommended for an MRI at that time. Right the utilization review dated 05/28/15 and 06/19/15 resulted in denials for an MRI lumbar spine as insufficient information had been submitted regarding the patient's neurological deficits.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient complaining of ongoing low back pain despite a previous surgical intervention. There is indication the patient had undergone MRI of the lumbar spine in 04/14. There is an indication the patient had developed a loss of sensation in the lower extremities. An MRI is indicated for patients who have demonstrated neurological deficits in the lower extremities following a one month course of conservative therapy. There is an indication the patient's complaining of a loss of sensation in the lower extremities. However, no information was submitted regarding the patient's recent completion of any conservative therapies addressing the lumbar complaints. Given the inadequate information regarding patient's recent therapeutic interventions addressing the lumbar complaints this request is not indicated. As such, it is the opinion of this reviewer that the request for an MRI of the lumbar spine with and without contrast is not recommended as medically necessary and the 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 KNOWLEDGBASE

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)