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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/03/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: MRI thoracic & lumbar, no contrast

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O. Board Certified Physical Medicine and Rehabilitation

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 thoracic & lumbar, no contrast is not medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: Patient is an individual. On xx/xx/xx, he was seen for a consultation for treatment of injuries sustained and reported he was on the back of an x trying to step across the x on the back of the x and he tripped losing his balance and fell forward twisting his back and falling on top of the patient. He noticed immediate back pain. He stated his right leg was numb within about 30 minutes of the injury. On exam, reflexes are hyperreflexic in general but left patella is graded at 1+ while the right patella and Achilles were graded 2+. Sensation was equal and strength was graded at 5+. Seated straight leg raise mildly uncomfortable on the right and negative on the left. On 06/16/15, an MRI of the lumbar spine was obtained noting mild spondylosis and degenerative disc disease with mild to moderate right neuroforaminal narrowing secondary to end plate osteophytic spurring and facet arthropathy.

On 06/08/11, x-rays of the thoracic spine revealed mild thoracic spondylosis without evidence of fracture. On 06/10/11, the patient returned to clinic. He had decreased perception of vibration and pinwheel in the right leg as compared to the left, and vibration and pinwheel were decreased in the lateral leg more so than the medial leg. He had weakness in his right EHL and to a lesser degree the left EHL. On 08/01/11, the patient returned to clinic, and denied lower extremity symptoms, numbness or tingling. On 03/31/15, the patient was seen for consultation. It was noted he had tried conservative measures including physical therapy and an MRI in 2011 had shown mild degenerative changes. On exam, reflexes were 2+ at the patella and 2+ at the left Achilles and 1+ at the right Achilles. He had decreased sensitivity to light touch and pinprick in the right anterior thigh. Updated MRI of the lumbar spine and thoracic spine was recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On 04/15/15, a preauthorization report noted the request for an MRI of the lumbar spine and thoracic spine was not authorized and it

was noted the patient had a previous MRI of the lumbar spine and it was stated there had been no changes in symptoms or physical examination findings since the last study was performed. Additionally, there were no complaints or abnormal physical findings of the thoracic spine and therefore the request was non-certified. On 06/22/15, an appeal determination letter was submitted also not authorizing the request for an MRI of the thoracic spine and MRI of the lumbar spine noting there were no complaints of radicular symptoms in the lower extremities, and there were no abnormal neurological examination findings regarding the lumbar or thoracic spine. There was no information that the symptoms had changed or worsened since the date of the previous exam and repeat studies were not warranted. The recommendation was for non-certification. The guidelines state that repeat studies such as repeat MRIs of the thoracic and/or lumbar spine should be reserved for those patients who have significant neurological findings or concern for tumor or infection. The records do not indicate the patient has a tumor or infection and do not indicate the patient has significant progressive neurological deficits since the previous MRI of the lumbar spine had been performed. The records also do not indicate the patient has significant pathology or symptoms related to the thoracic spine. Therefore, it is the opinion of this reviewer that the request for an MRI thoracic & lumbar, no contrast is not 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 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)