

Becket Systems

An Independent Review Organization
815-A Brazos St #499
Austin, TX 78701
Phone: (512) 553-0360
Fax: (207) 470-1075
Email: manager@becketystems.com

DATE NOTICE SENT TO ALL PARTIES: Jun/01/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: MRI, lumbar spine W or W/O contrast lumbar spine series with flexion/extension and AP/lateral views (standing and weight bearing)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Neurosurgery

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 this reviewer's opinion that medical necessity for the requested MRI, lumbar spine W or W/O contrast lumbar spine series with flexion/extension and AP/lateral views (standing and weight bearing) has not been established

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who was injured on xx/xx/xx when she slipped and fell, then developed low back pain radiating to the left anterior thigh. The patient is status post lumbar microdiscectomy, laminectomy, foraminotomy and facetectomy at L4-5 to the left on 09/04/14. Post-operative assessment with on 12/15/14 noted near complete resolution of pre-operative pain. The patient denied any pain numbness and tingling in the lower extremities. The patient was referred to post-operative rehabilitation. The patient continued with physical therapy through December of 2014. The patient was seen by on 03/02/15 with complaints of severe onset of low back pain without lower extremity symptomology while completing physical therapy. Physical examination noted mild weakness at the extensor hallucis longus to the left. There was no sensory loss evident and the patient had no difficulty with heel or toe walking. Straight leg raise was positive to the left at 50 degrees and negative to the right. Due to the interval change in the neurological status recommended an updated MRI and a lumbar spine series to rule out instability. The requested MRI and flexion/extension radiographs of the lumbar spine were denied on 03/25/15 as there was no evidence of any significant change in patient's symptoms or new clinical documentation of significant pathology. The request was again denied on 04/09/15 as the patient had no lower extremities symptoms and denied any numbness and tingling. Peer to peer conversation occurred with indicating they were wishing to see how the patient progressed within a few weeks then request MRI and radiographs.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient reported an exacerbation of her low back pain following the lumbar decompression procedure on 09/04/14 while continuing with physical therapy. The patient specifically denied any lower extremities complaints such as numbness, tingling or perceived weakness. The patient's physical examination findings noted some weakness at the left extensor hallucis longus; however, this was also a noted pre-

operative finding. Given the patient's lack of complaints in the lower extremities and no evidence of any new neurological findings on physical examination, repeat imaging studies at this time would not be indicated to include both MRI and radiographs. Furthermore based on peer to peer conversation that occurred on the appeal request for the diagnostic tests, the attending doctor, indicated that they were waiting to see how the patient progressed before ordering imaging studies. As there is no current evaluation of this patient noting any continuing lower extremities complaints or a new neurological deficit on physical examination, it is this reviewer's opinion that medical necessity for the requested MRI, lumbar spine W or W/O contrast lumbar spine series with flexion/extension and AP/lateral views (standing and weight bearing) has not been established 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)