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DATE NOTICE SENT TO ALL PARTIES: June/3/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: MRI spinal canal lumbar with and without contrast

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DO 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 MRI spinal canal lumbar with and without contrast is not medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is an individual. On XX/XX/XX, an MRI of the lumbar spine revealed from T12-L1, down to L3-4, there is no disc herniation, canal or foraminal stenosis and the facet joints were normal. At L4-5, there was mild disc narrowing and desiccation, and there was a broad based right foraminal disc protrusion, compressing the exiting right L4 nerve root. There was no central canal or left foraminal stenosis. The facet joints were unremarkable. At L5-S1, there was mild to moderate disc narrowing and desiccation. There was a broad based central disc protrusion effacing the ventral thecal sac and abutting the bilateral S1 nerve roots. This disc material was slightly more prominent to the left midline and caused greater mass effect upon the left S1 nerve root. The central canal was mildly narrowed. The neural foramina were adequate bilaterally and there was mild bilateral facet hypertrophy. On XX/XX/XX, the patient returned to clinic. He reported low back pain with pain radiating to the posterior thigh and calf on the left. On exam, he had reduced range of motion and straight leg raise was normal bilaterally. Femoral stretch test was negative on the right and left and sitting straight leg raise was positive for contralateral leg and ipsilateral leg pain. Muscle groups tested in the lower extremities were considered normal, and the left ankle jerk was hypoactive. Light touch sensation was considered normal. On XX/XX/XX, the patient was taken to surgery for a left L5-S1 hemilaminectomy, decompression of the left nerve root, excision of the herniated disc with a foraminotomy at L5-S1. On XX/XX/XX, the patient returned to clinic and his left ankle jerk was present but hypoactive. On XX/XX/XX, the patient returned to clinic and he reported intermittent pain in the left leg which had become more constant. On exam, his left Achilles reflex was absent, and there was minimal sciatic notch tenderness and sitting route test was negative.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On XX/XX/XX, an Adverse Determination Letter was submitted for the requested MRI of the lumbar spine with and without contrast, stating there was a lack of substantial documentation of changes in the physical exam

findings or progressive neurological deficits and a repeat imaging study would not be supported. The request was non-certified.

On XX/XX/XX, an Adverse Determination Letter stated that the request for an MRI of the spinal canal lumbar spine with and without contrast was not medically necessary as there had been no substantial changes in the physical exam findings or progressive neurological deficits to support the request.

The patient was neurological intact with the exception of a hypoactive left ankle jerk soon after the previous MRI. The most recent exam found the left ankle reflex absent. There is no indication of a significant change in clinical findings to warrant a repeat study.

It is the opinion of this reviewer that the request for MRI spinal canal lumbar with and without 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)