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An Independent Review Organization

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Notice of Independent Review Decision

Case Number:

Date of Notice: 02/23/2016

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

MRI lumbar spine without contrast

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)

Patient Clinical History (Summary)

The patient is a male. On XX/XX/XX, the patient was seen with complaints of pain to the cervical spine and lumbar spine. He noted a flexion/extension injury to both anatomic sites. On physical examination, straight leg raise was positive bilaterally at 20 degrees, and he reported diminished sensation in the left foot. Otherwise motor and sensory and reflexes were symmetrical and intact. X-rays of the lumbar spine showed no fracture or dislocation. An MRI was to be to be obtained.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On XX/XX/XX, a notification of adverse determination letter was submitted for the requested MRI lumbar spine without contrast, and used Official Disability Guidelines low back chapter as a reference. It was noted the patient presented with lumbar pain and neurological deficits based on physical examination findings, but clear evidence of a physician directed conservative care was not identified. Therefore the request was non-certified.

On XX/XX/XX, a notification of adverse determination was submitted for the requested MRI lumbar spine, and Official Disability Guidelines low back chapter was utilized. It was noted there was discrepancy in the XX/XX/XX report which reported both diminished superficial tactile sensation in the left foot, and bilaterally symmetrical and intact motor and sensory reflexes. Additionally, there is no clear evidence of an adequate course of conservative treatment for the lumbar spine and the quest was non-certified.

The guidelines state there should be identified red flags, such as neurological deficits, and or documented conservative care, prior to ordering an MRI of the lumbar spine. The records submitted for this review include the XX/XX/XX report which reported both diminished superficial tactile sensation in the left foot, and bilaterally symmetrical and intact motor and sensory reflexes. This should be clarified.

Is the opinion of this reviewer that the request for an MRI lumbar spine without contrast is not medically necessary and 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 and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)