

# Clear Resolutions Inc.

An Independent Review Organization

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**DATE NOTICE SENT TO ALL PARTIES:** Jan/15/2016

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** MRI Spinal Canal Lumbar W/O 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.** Given the lack of information regarding any significant changes in the patient's clinical presentation, the request for MRI Spinal Canal Lumbar W/O contrast is not indicated as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who reported an injury to his low back. The clinical note dated XX/XX/XX indicates the patient had attempted to lift a 90 lb. box while standing on a pallet when the pallet broke beneath him causing him to twist his back. The patient reported significant levels of pain the following day. The patient was subsequently diagnosed with a herniated lumbar disc and treated with medications, physical therapy, and an epidural injection which resulted in no significant benefit. The patient described a pinching and pulling sensation in the lumbar region. The patient rated the pain as 0-5/10. Numbness was identified in the left lower extremity that remained constant but with variable progressions. Radiating pain was also identified into the buttocks, posterior thigh, and posterior lower leg all the way to the lateral region of the left foot in the lateral 3 toes. Upon exam, the patient was able to demonstrate 5/5 strength throughout the lower extremities. Absent reflexes were identified at the posterior tibialis bilaterally. X-rays of the lumbar spine revealed an essentially normal study. There is an indication the patient had undergone an MRI of the lumbar spine on XX/XX/XX which revealed an extruded disc at L5-S1. The clinical note dated XX/XX/XX indicates the patient continuing with low back pain. No significant changes were identified with the patient's clinical presentation. Absent reflexes continued in the L5 region. There is an indication the patient had a positive straight leg raise on the right. The patient had been recommended for an MRI of the lumbar spine.

**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 with associated absent reflexes identified within the L5 distributions bilaterally. There is an indication the patient had undergone an MRI of the lumbar spine on XX/XX/XX which revealed significant findings at the L5-S1 level. Repeat MRI studies are indicated for the lumbar region provided the patient meets specific criteria to include significant changes identified with the patient's symptoms or the patient having developed new pathology. No information was submitted regarding the patient's significant changes involving any symptoms associated with the lumbar region.

Additionally, no information was submitted regarding any new development of significant pathology. Given the lack of information regarding any significant changes in the patient's clinical presentation, the request for MRI Spinal Canal Lumbar W/O contrast is not indicated 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 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)