

# US Decisions Inc.

An Independent Review Organization  
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**DATE NOTICE SENT TO ALL PARTIES:** Feb/08/2016

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** MRI Lumbar Spine

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** MD, Board Certified Family Medicine

**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.**

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who reported an injury to his low back. The clinical note dated XX/XX/XX indicated the patient complaining of chronic low back pain. There is indication the patient had previously been diagnosed with lumbar disc displacement as well as lumbar spondylosis. A previous medial branch block had been completed on XX/XX/XX which resulted in 60% improvement in pain level. Bilateral facet blocks were completed at L3-4 and L5-S1 strength at the patient's pain returned and had been recommended for bilateral facet blocks. The patient reported radiating pain into the left buttocks and occasionally into the thigh. The note indicates the patient utilizing hydrocodone and Skelaxin. Upon exam a patient was able to demonstrate 4+/5 strength in both iliopsoas regions. The patient was able to demonstrate 70 degrees of lumbar flexion and 50 degrees of extension. The procedure note dated XX/XX/XX indicates the patient having undergone bilateral L3-4 and L4 L5-S1 lumbar facet blocks. X-rays of the lumbar spine completed on XX/XX/XX revealed no evidence of abnormal motion. A spinal fusion had been completed L4-5. The clinical note dated XX/XX/XX indicates the previous rhizotomies provided no significant benefit. The patient continued use of hydrocodone and Skelaxin. 3+/5 strength was identified at the iliopsoas. Range of motion deficits continued to a to include 50 degrees of lumbar flexion and 10 degrees of extension. The clinical note dated XX/XX/XX indicates the patient continuing with low back pain with radiating pain to the lower extremities, left greater than right. The patient continued with 3+/5 strength at the iliopsoas. The note indicates the patient having been recommended for an MRI of the lumbar spine. The utilization reviews dated XX/XX/XX and XX/XX/XX resulted in denials as insufficient information had been submitted regarding the patient's completion of any therapeutic interventions.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The documentation indicates the patient complaining of a long history of ongoing low back pain. There is indication the patient had undergone x-ray of the lumbar spine which revealed significant findings, to include a 7mm anterior lithiasis of L3 and with respect to L4. MRI of the lumbar spine is indicated for patients who completed a course of conserve therapy addressing the low back complaints. There is indication the patient had undergone a diagnostic medial branch block as well as

rhizotomy resulting in no significant benefit here however, no other information was submitted regarding the patient's completion of any formal therapeutic intervention dressing the low back complaints. Given the minimal information regarding the patient's completion of any conservative therapeutic interventions addressing the lumbar region complaints, the request is not indicated as medically necessary. As such, it is the opinion of this reviewer that the request for an MR lumbar spine 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)