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An Independent Review Organization
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Date: 5/14/2018 8:58:12 PM CST

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Lumbar MRI

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Orthopaedic Surgery

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Overturned	Disagree
☐ Partially Overtuned	Agree in part/Disagree in part
☐ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:
This case involves a now XXXX -year-old XXXX with history of an occupational claim XXXX. The mechanism of injury is detailed XXXX. Prior treatment included chiropractic therapy and activity modification. The initial evaluation on XXXX, documented the patient had constant severe pain and rated the pain a 9/10 on visual analog scale. The pain was described as shooting, sharp, aching, tight, burning, and stiff and aggravated with activity/movement. On physical examination of the lumbar spine, the patient had a reduced range of motion and mild spasm in the mid thoracic and lumbosacral spine. All neurological tests were within normal limits and grossly intact bilaterally. The current diagnoses are documented as headache, pain in the lumbar spine, lumbar spine sprain, lumbar radiculopathy, pain in the thoracic spine, thoracic spine strain, and muscle spasm. The treatment plan included rehabilitation. This request was previously denied given there was no neurological deficits or positive examination findings to support imaging of the lumbar spine.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
According to the provided documentation, the patient had low back pain and rated the current pain a 9/10 on visual analog scale. This patient had continued pain complaints refractory to conservative management. Given the patient's severe complaints imaging would be indicated to assist with further treatment planning. As such, this request is appropriate for this patient.

Based on the above documentation, the requested Lumbar MRI is medically necessary and the review outcome is overturned.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Low Back Chapter, MRI (magnetic resonance imaging)