Applied Assessments LLC

An Independent Review Organization
900 Walnut Creek Ste. 100 #277
Mansfield, TX 76063
Phone: (512) 333-2366
Fax: (888) 402-4676
Email: admin@appliedassessmentstx.com

Date: 5/14/2018 7:19:26 PM CST

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
MRI Thoracic Spine

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

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

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

PATIENT CLINICAL HISTORY [SUMMARY]:
This case involves a now XXXX year-old XXXX with a history of an occupational claim from XXXX. The mechanism of injury is detailed as the patient was XXXX. Although XXXX is XX, XXXX did report hitting XXXX head. The patient was taken to the XXXX emergency center whereupon examination and imaging was completed. A CT of the cervical spine without contrast showed no acute appearing intracranial abnormalities. CT of the thoracic spine showed good alignment with no fractures. Additionally, a CT of the head/brain was normal. The patient also had a chest x-ray with no acute cardiopulmonary disease. The patient reported having head pain and left shoulder pain with midline tenderness from T2-T3 and left arm tenderness to the midshaft of the humerus. The patient was subsequently discharged from the emergency room with pain medications. XXXX was seen again on XXXX. XXXX reported having constant pain rated at 9/10 on visual analog scale. XXXX describes symptoms as sharp, shooting, aching as well as tight, burning and stiff. Symptoms are aggravated with activities and movement. On physical examination, the patient was negative for specialty testing of the cervical spine. Motor strength was +5/+5 with reflexes +2 and equal. Sensation was within normal limits and grossly intact bilaterally from C2-S1. Range of motion of the lumbosacral spine was reduced with severe pain was severe muscle spasms of the mid thoracic and lower lumbosacral spine, erector spinae and hamstring musculature with increased tenderness on palpation. Additional findings included positive straight leg raise testing, Minor's testing and Bechterew's test. The patient also had a positive Coombs test at levels T10-L5. There was slight motor strength reduction in the iliopsoas and quadriceps muscles at +4/+5. On palpation, the patient had tenderness at the lower thoracic region of a moderate to severe degree with the lumbar region indicated as severe. There is also tenderness to the lateral rib cage on the right side at a moderate to severe level. The patient had thoracic and lumbar paraspinal muscles active upon palpation with the thoracic region fixed at levels T5-T11. There was thoracic and lumbar paraspinal

musculature stiffness and moderate tension noted when breathing to the right side of the cage. The diagnoses were listed as headache, pain in the lumbar spine, lumbar spine sprain, lumbar radiculopathy in addition to pain in the thoracic spine, thoracic spine sprain and muscle spasms. A prior request for MRI of the thoracic spine was denied on XXXX. The rationale stated that this test is not recommended until at least a month of conservative therapy for uncomplicated low back pain. There was reference to the initial evaluation and neurological and objective findings, but no updated examination was provided for review. An appeal request for the MRI was again denied on XXXX. The rationale stated that there is a lack of sufficient information with no evidence of neurological findings. The physician was going to fax in a reexamination report. However, the report was not received. This request is in regards to the MRI of the thoracic spine.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The Official Disability Guidelines have indicated that MRI is indicated for the upper back/thoracic spine for patients who have neurological deficits. However, there is no reference to this patient having any neurological findings that would support the need for MRI of the thoracic spine. The physician did not submit any updated information pertaining to this patient having any progression of neurological symptoms and no indication that the patient had a trial of nonoperative treatment measures before consideration of pursuing advanced imaging. The patient was not a surgical candidate requiring MRI for diagnostic purposes and/or treatment planning.

As such, in accordance with the previous denial, the request for MRI thoracic spine is not medically necessary.

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

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
☐ MILLIMAN CARE GUIDELINES
☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
☐ TEXAS TACADA GUIDELINES
☐ TMF SCREENING CRITERIA MANUAL

Official Disability Guidelines (ODG), Treatment Index, 15th Edition (web), 2018, Neck and Upper Back Chapter, Magnetic resonance imaging (MRI).