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DATE NOTICE SENT TO ALL PARTIES: 1/16/18

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a MRI spinal canal Lumbar without contrast.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a MRI spinal canal Lumbar without contrast.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a XX-year-old XXXX who was injured on XXXX in a mechanism that was not denoted. The claimant was diagnosed with a sprain of the lumbar spine and a sprain of the cervical spine. An evaluation on XXXX, revealed that the claimant was having continued pain in the neck and lower back. The claimant rated current pain in the lower back as 9/10 on a Visual Analog Scale with subjective complaints of pain in the bilateral lower extremities. It was noted that the claimant had completed a trial of physical therapy which did not help and underwent epidural steroid injections of the cervical and lumbar spine. It was noted that the claimant had previous MRIs of the lumbar spine and cervical spine completed on XXXX; the reports were not made available for review. The physical examination of the lumbar spine revealed no evidence of atrophy of the lower extremities and there was no tenderness or spasticity in the lower back. The claimant was able to bend forward to the knee level and there were negative Patrick test and pelvic tilt test, but there was a positive straight leg raise bilaterally and a positive cross leg straight leg raise bilaterally. There was no evidence of weakness in the bilateral

extremities and no loss of sensation noted in the bilateral lower extremities, and deep tendon reflexes were symmetrical.

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

The claimant has continued pain in the neck and lower back. According to the guidelines, a repeat MRI is only recommended if there are significant changes in symptoms and clinical exam findings suggestive of significant pathology. It was reported that the claimant was complaining of new neurological symptoms causing an increase in pain of the lower back, but there were no clinical exam findings documented to support radiculopathy of the lower extremities to include weakness, loss of sensation, and loss of deep tendon reflexes to warrant repeat imaging. The request for lumbar MRI without contrast is not certified.

Official Disability Guidelines – Treatment in Workers' Compensation ODG Treatment Integrated Treatment/Disability Duration Low Back (Acute and Chronic) (updated XXXX) ODG guidelines MRI (magnetic resonance imaging) Recommended for indications below. MRI is the test of choice for patients with prior back surgery, but for uncomplicated low back pain with radiculopathy, this test is not recommended until after at least one month of conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). Indications for imaging -- Magnetic resonance imaging: - Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation).

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**

☐ **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)**