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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/04/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI of the lumbar spine without contrast 72148

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

MD, 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines, Low Back Chapter, MRIs

Utilization review determination 03/01/11 regarding non-certification MRI of the lumbar spine without contrast

Reconsideration/appeal request review 03/15/11 regarding non-certification MRI of the lumbar spine without contrast

Law Office of 03/21/11

History/physical/treatment and physical activity report 01/20/11, 01/27/11

Progress notes urgent care centers 03/17/11

Office notes/reevaluation report 11/02/10 and 03/03/11 MD

Office notes/reevaluation 02/15/11 MD

Pre-authorization request 03/02/11 regarding MRI lumbar spine

Fax cover sheet 02/24/11

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a male whose date of injury is xx/xx/xx. The mechanism of injury is described as he was lifting heavy wooden material at a when he felt a sharp pain to the lower back with a burning sensation radiating to both his thighs. He complains of persistent low back pain with pain radiating to the leg down to his calves worse on the right. Records indicate the injured employee was treated conservatively with physical therapy and activity modification.

A pre-authorization request for MRI of the lumbar spine without contrast was reviewed by Dr. on 03/01/11. Dr. determined the request was not certified as medically necessary, noting that documentation provided for the review did not include any clinical exam findings, prior treatment history or rationale for the requested study. In addition Dr. noted there was no documentation of a condition/diagnosis with supportive subjective/objective findings for which

an MRI is indicated and therefore medical necessity has not been established.

A reconsideration/appeal request was reviewed by Dr. on 03/15/11 and the request for MRI of the lumbar spine without contrast was non-certified. Dr. noted that the documentation submitted for review elaborates the injured employee complaining of low back pain with a radiculopathy component noted into the bilateral calves. No documentation was submitted regarding the injured employee's one month long conservative therapy. Dr. noted there were no exceptional factors noted in the documentation and the request does not meet guideline recommendations.

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

Based on the information provided for this review, the request for MRI of the lumbar spine without contrast 72148 is found by this reviewer to be medically necessary. The injured employee is noted to have sustained a lifting injury to the low back on xx/xx/xx. He has complaints of low back pain with pain radiating to the legs right worse than left. The initial review noted that there were no clinical exam findings, prior treatment history or rationale for MRI, and there was no condition/diagnosis for which MRI is indicated. The records available at the time of the reconsideration / appeal review reported limited range of motion of the lumbar spine with flexion 25 degrees, extension 15 degrees, left and right lateral flexion 15 degrees, straight leg raise positive bilaterally at 50 degrees and motor exam strength 4/5 in the lower extremities. Deep tendon reflexes were +2/4. A reevaluation on 03/03/11 reported lumbar range of motion flexion 50 degrees, extension 10 degrees with referred pain to the right leg. Straight leg raise was positive on the right at 50 degrees, left at 60 degrees. Deep tendon reflexes were +2/4, slightly sluggish on the right. Sensory exam revealed hypoesthesia consistent with L4-5 L5-S1 distal pathology. Motor strength was 4/5 on the right. The injured employee was noted to have been treated conservatively with physical therapy, anti-inflammatory medications, and rest with no significant improvement. Given the current clinical data, medical necessity is established for MRI of the lumbar spine without contrast 72148 as the patient has low back pain with radiculopathy unresponsive to conservative therapy.

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 KNOWLEDGBASE
- 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)