

RYCO MedReview

Notice of Independent Review Decision

DATE OF REVIEW: 12/06/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient MRI of the lumbar spine with and without contrast

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

Board Certified in 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Outpatient MRI of the lumbar spine with and without contrast - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Payment of Compensation or Notice of Refused/Disputed Claim forms dated 07/21/03 and 10/08/03

Evaluations with M.D. dated 08/10/04, 09/13/04, 10/12/04, 12/13/04, 12/23/04, 04/04/05, 05/13/05, 06/09/05, 07/21/05, 08/25/05, 12/29/05, 05/17/06, 06/15/06, 07/11/06, 08/01/06, 08/30/06, 10/02/06, 10/30/06, 12/28/06, 01/30/07, 04/24/07, 06/11/07, and 08/21/07

Required Medical Evaluations (RMEs) with M.D. dated 08/30/05, 09/18/06, and 04/03/07

PLN-11 forms from the insurance carrier dated 03/27/07 and 04/20/07

Notices of Intent to Issue an Adverse Determination, according to the ODG, from Forte dated 08/31/07 and 10/17/07

Letters of non-authorization, according to the ODG, from Forte dated 09/04/07 and 10/18/07

The ODG was not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

On 07/21/03, the insurance carrier denied that the degenerative disc disease of the lumbar spine was related to the compensable injury. On 10/08/03, the insurance carrier also denied that the bony foraminal stenosis and facet hypertrophy were related to the original injury. On 08/10/04, Dr. recommended an MRI of the lumbosacral spine. On 10/12/04, Dr. recommended a reexploration and further decompression of the lumbar spine. On 08/25/05, Dr. refilled Reglan and a muscle relaxant. On 08/30/05, Dr. felt the patient would only require medication maintenance only. On 12/29/05, Dr. recommended an MRI of the lumbosacral spine. On 08/30/06, Dr. continued Vicodin ES, Xanax, Ambien, and Soma. On 09/18/06, Dr. felt the patient's current symptoms were related to the compensable injury. On 03/27/07, the insurance carrier provided a PLN-11 form disputing entitlement of benefits related to the injury or the right hip. On 04/03/07, Dr. felt there was no relationship between the hip complaints and the original injury. On 04/20/07, the insurance carrier also provided a PLN-11 form disputing entitlement of benefits related to trochanteric bursitis. Dr. recommended an EMG/NCV study, Vicodin, and Soma on 04/24/07. On 08/21/07, Dr. recommended an MRI of the lumbosacral spine. On 09/04/07 and 10/18/07, Forte wrote letters of non-authorization for the MRI.

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

The patient had a prior MRI after her last surgery, as noted by Dr. on 10/30/06. The patient has a stable neurological examination and there is no evidence of any new neurologic deficits. According to the ODG, while MRIs are the tests of choice with prior back surgery, "repeat MRIs are indicated only if there has been progression of the neurologic deficits". As this patient does not

have any objective evidence of new neurologic deficit, a new outpatient MRI of the lumbar spine with and without contrast is neither reasonable nor 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
- 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)