

IRO NOTICE OF DECISION – WC

DATE OF REVIEW: 05-09-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Denial of preauthorization approval for MRI Lumbar with and without gadolinium

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

Certified by the Board
Physical Medicine and Rehabilitation

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.

Injury Date	Claim #	Review Type	ICD-9 DSMV	HCPCS/NDC	Upheld/Overturn
		Prospective			Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notices of Preauthorization denial (03-09-07 and 03-28-07)
Practitioner note dated 2/21/2007
Letter dated 3/12/2007

PATIENT CLINICAL HISTORY [SUMMARY]

The claimant sustained injury while lifting plywood at work. The claimant is status post prior fusion at the L5-S1 level. Left sided L4-5 ESI performed on 2/7/2007. On the 2/21/2007, the claimant had complaints of low back, bilateral buttock, and bilateral anterior thigh pain, left greater than right.

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

A decision in support of the Lumbar MRI is granted. The claimant has not completed an MRI in several years. The claimant's physician is evaluating the claimant for adjacent level disc disease. The claimant has clinical symptomatology that could be indicative of pathology at L4-5.

In addition, MRI is indicated for its specificity and sensitivity at detecting additional pain generators, including but not limited to disc and/or facet disease, Central of neuroforaminal stenosis, spondylosis and spondylolisthesis and nerve impingement. Several of these conditions classically present with axial back pain and do not always manifest with radiculopathy or myelopathy findings.

Bibliographic Sources

Management of degenerative disc disease above an L5-S1 segment requiring arthrodesis. Because magnetic resonance imaging now provides us with far more information on the "health" of radiographically normal intervertebral discs, the treatment of dehydrated or degenerated discs adjacent to a fusion is becoming more problematic.

Spine. 1999 Jun 15;24(12):1268-70

AECOM provides limited point of reference for chronic pain conditions in general and adjacent disc disease in particular. In Chapter 12, page 303 states: If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (MRI for neural or other soft tissue, CT for bony structures).

Likewise, InterQual does not have specific guidelines dedicated to classic chronic lumbar pain syndromes such as adjacent level disc disease.

**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 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
- 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)