

US Decisions, Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: 06/03/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Magnetic Resonance (EG, proton) Imaging, spinal canal and contents, lumbar without contrast

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

M.D., Board Certified Neurosurgeon with additional training in Pediatric Neurosurgery

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)

Upon independent review the reviewer finds that the requested Magnetic Resonance (EG, proton) Imaging, spinal canal and contents, lumbar without contrast is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters 3/28/08, 4/16/08

ODG Guidelines and Treatment Guidelines

MD 5/6/08, 3/18/08, 2/19/08, 12/20/07, 4/26/07, 3/15/07, 1/18/07, 11/30/06

MD 10/31/07, 10/11/07, 10/5/07, 10/3/07, 7/31/07, 6/26/07, 5/1/07, 3/20/07, 1/9/07

MD 11/15/06, 10/23/06, 10/6/06, 9/29/06

MRI Lumbar Spine w/o Contrast 4/23/08

MRI Report 9/26/06
PT 3/1/07, 2/16/07, 2/12/07, 2/5/07, 1/31/07, 1/24/07
12/6/06, 10/26/06, 10/18/06, 10/13/06, 10/11/06, 10/4/06
Electrodiagnostic Study, MD
EMG and NCV Study 1/8/07
Medical Review Notes 3/27/08, 4/15/08
Pre-Authorization Request
Diagnostic Requisition Form 3/25/08
MD Letter of Appeal 4/11/2008

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year-old male who complains of back pain with radiation to the lower extremities since a work-related injury in xx/xx/xx. He has been treated with physical therapy, pain medications, and injections. Neurological examination is normal. Electrophysiologic studies, 01/08/2007, revealed a left L5 radiculopathy. A new MRI of the lumbar spine, 04/23/2008, did not reveal any significant changes. There is mild central stenosis at L4-L5 with no disc bulge or neuroforaminal stenosis. There is disc desiccation at his level. At L5-S1 is a small disc protrusion, contacting and displacing the left S1 nerve root. There is mild facet arthropathy, mild central canal, and left foraminal stenosis at this level. The item in dispute is Magnetic Resonance (EG, proton) Imaging, spinal canal and contents, lumbar without contrast.

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

Upon independent review the reviewer finds that the requested Magnetic Resonance (EG, proton) Imaging, spinal canal and contents, lumbar without contrast is not medically necessary.

The repeat MRI of the lumbar spine is not medically necessary. There is no clear documentation that the patient was experiencing a change, or worsening of the symptoms. There is no documentation of a change in neurological deficits or signs. According to the ODG, "repeat MRI's are indicated only if there has been progression of neurologic deficit. ([Bigos, 1999](#)) ([Mullin, 2000](#)) ([ACR, 2000](#)) ([AAN, 1994](#)) ([Aetna, 2004](#)) ([Airaksinen, 2006](#)) ([Chou, 2007](#))". This has not been demonstrated in this case.

References/Guidelines

ODG "Low Back" chapter
MRI

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)