

# Applied Resolutions LLC

An Independent Review Organization  
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## Notice of Independent Review Decision

**DATE OF REVIEW:** 05/26/2008

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Repeat lumbar MRI 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 repeat lumbar MRI without contrast is medically necessary

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 1/25/08, 2/15/08, 4/9/08, 4/30/08  
ODG Guidelines and Treatment Guidelines  
Follow-Up Office Visit 4/1/08  
MD letter 1/18/08  
Intermediate Office Visit 1/15/08  
MRI Report 12/13/06  
Follow-Up Evaluation 1/28/03  
MD Return to Work Note 12/11/06  
Work Status Report 12/5/06  
Established Office Visit 12/5/06

MD letter to MD 12/19/06  
Pre-Authorization Requests 1/27/08, 2/7/08, 4/3/08, 4/22/08  
MD Reconsideration Letter 4/22/08  
Print Notes Utilization Review 1/22/08-4/4/08  
Print Notes Utilization Review 4/7/08- 5/6/08

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a male with a date of injury xx/xx/xx. His initial injury was xx/xx/xx when he fell down pushing a car in a snowstorm. An MRI of the lumbar spine at the time showed disc dessication at L4-L5 and L5-S1. A more recent MRI 12/13/2006 showed interval development of posterior left paramedian and inferior disc extrusion at L5-S1 compressing the left S1 nerve root. He has had multiple epidural steroid injections. The patient is now complaining of intermittent back pain, radiating down both legs, left greater than right. There is now an ache in the left leg at all times. There is numbness in the left great toe, especially at night. The patient is also complaining of new erectile dysfunction.

His neurological examination 12/2006 was normal. According to a clinic note 01/15/2008, there is weakness noted in the left quadriceps and toe flexors. On 04/2008 there is also a decreased knee jerk on the left and decreased ankle jerk on the left. There is some giveaway weakness in the left EHL. The provider is recommending a repeat lumbar MRI.

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

The repeat MRI of the lumbar spine without contrast is medically necessary. According to the ODG, repeat MRI's are indicated for progressive neurological deficits. In this case, there has been a progression of deficits. When the last MRI was performed 12/2006, the neurological examination was normal. Now, as the provider correctly points out, there is objective evidence of L4, L5, and S1 nerve root dysfunction. There are decreased left ankle and knee reflexes, and some giveaway weakness in the left hallicus longus. There is also numbness over the great toe on the left. These are all new findings. Moreover, the patient is clinically doing worse and is a likely surgical candidate. The repeat MRI of the lumbar spine, for the reasons stated above, is therefore medically necessary.

### **References/Guidelines**

2008 *Official Disability Guidelines*, 13th edition  
"Low Back" chapter

### **Indications for imaging -- Magnetic resonance imaging (MRI):**

Repeat MRI's are indicated only if there has been progression of neurologic deficit.

**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)