



Medical Review Institute of America, Inc.
America's External Review Network

DATE OF REVIEW: August 13, 2009

IRO Case #:

Description of the services in dispute:

1) Review for lumbar MRI, EPB, and SI. CPT codes: #J1040, #J1030, #27096, #94760, #62282, #72148.

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician who provided this review is board certified by the American Board of Neurological Surgery. This reviewer is a member of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons. The reviewer has completed training in both pediatric and adult neurosurgical care. This reviewer has been in active practice since 2001.

Review Outcome

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld

The request for lumbar MRI and neurolysis is not medically necessary. There is no objective clinical evidence in the submitted documentation of a progress focal neurologic deficit that would require imaging studies at this time. There is no clinical documentation of patient's response to prior or articular facet injections. Without evidence that the patient has responded to facet injections, neurolysis is not medically necessary.

Information provided to the IRO for review

1. Records from the State:

- Confirmation of Receipt of a Request for Review 7/24/09, (3 pages)
- Request for Review by an Independent Review Organization 7/20/09 (3 pages)
- Letter of Denial from Insurance 6/11/09 (6 pages)
- Appeal Denial Letter from Insurance 6/26/09 (6 pages)

2. Records from Insurance Company

- Letter of Denial from Insurance 6/11/09 (6 pages)
- Appeal Denial Letter from Insurance 6/26/09 (6 pages)

X-ray Examination Sheet from Co. 5/13/09 (1 page)
Office Note from International Disease Prevention Clinic 5/13/09 (3 pages)
Radiology Report of a 2-View Lumbar Spine from Doctor's Hospital 5/21/09 (1 page)
Office Note from M.D. 6/5/09 (2 pages)
Letter from M.D. 6/19/09 (2 pages)

Patient clinical history [summary]

The patient is a xx-year old male who sustained an injury on xx/xx/xx. A clinical note from 05/13/2009, states the patient has lower back pain radiating to the bilateral legs, left greater than right. The patient has associated numbness and muscles spasms. A physical exam was not performed at this visit. The patient underwent a right gluteal injection of Toradol 30mg. The radiographs from the lumbar spine dated 05/21/2009, report no obvious ideology for acute pain. Follow up on 06/02/2009, states the patient continues to complain of low back pain radiating in the legs bilaterally with intermittent numbness. The physical exam reports positive straight leg raise test at 70 degrees bilaterally. Tenderness is noted over the lumbar spine.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

The request for lumbar MRI and neurolysis is not medically necessary. There is no objective clinical evidence in the submitted documentation of a progress focal neurologic deficit that would require imaging studies at this time. The most recent physical exam does not report any focal neurologic deficits to include sensory, decreased sensation, pathologic reflexes, or significant motor weakness in the lower extremities that would be consistent with any pathology in the lumbar spine. The request for neurolysis is not recommended, as there is no indication of what levels are being requested for neurolysis. Additionally, there is no clinical documentation of patient's response to prior or articular facet injections. Without evidence that the patient has responded to facet injections, neurolysis is not medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

ODG Guidelines Low Back Chapter

Indications for imaging -- Magnetic resonance imaging:

- Thoracic spine trauma: with neurological deficit
- Lumbar spine trauma: trauma, neurological deficit
- Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit)
- Uncomplicated low back pain, suspicion of cancer, infection
- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. (For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.) (Andersson, 2000)

- Uncomplicated low back pain, prior lumbar surgery
- Uncomplicated low back pain, cauda equina syndrome
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, painful
- Myelopathy, sudden onset
 - Myelopathy, stepwise progressive
- Myelopathy, slowly progressive
- Myelopathy, infectious disease patient
- Myelopathy, oncology patient

Criteria for use of facet joint radiofrequency neurotomy:

(1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections).

(2) While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at = 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period.

(3) Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function.

(4) No more than two joint levels are to be performed at one time.

(5) If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks.

(6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy

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