

SENT VIA EMAIL OR FAX ON
Feb/23/2009

I-Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/23/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI of the Lumbar Spine

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

M.D., Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 1/20/09, 1/31/09

ODG Guidelines and Treatment Guidelines

SOAP Notes: 08/30/04, 09/01/04, 09/02/04, 09/03/04, 09/07/04, 09/08/04, 12/16/04, 12/29/04, 01/03/05, 01/10/05, 02/23/05, 03/09/05, 04/06/05, 05/16/05, 01/08/09

Radiology Report: 09/03/04

Nerve Conduction Study: 09/07/04

MRI Report: 09/15/04

Spinal Sonography: 11/15/04

Electromyelography Report: 11/15/04

Office Note, Dr. : 11/17/04

Letter: 01/15/09 and 01/23/09

Medical Evaluation, Dr.: 03/29/05

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who works as a xxx at a xxxx. She reportedly tripped over a

telephone cord and fell on xx/xx/xx with resultant complaints of low back and bilateral leg pain. The claimant treated with chiropractic management, medications, activity modification and a weight loss program without significant benefit. Lumbar, sacral and coccyx radiographs performed on 09/03/04 noted mild lumbar degenerative changes. Nerve conduction studies of the bilateral lower extremities conducted on 09/07/04 noted bilateral tibial ankle, peroneal ankle and lateral plantar motor neuropathy. Lumbar MRI evaluation completed on 09/15/04 indicated L3-4 moderate bilateral degenerative facet hypertrophy with a small annular tear; an L4-5 mild posterior disc protrusion with severe degenerative facet joint hypertrophy with bilateral lateral recess and foraminal narrowing and a small annular tear; L5-S1 mild disc bulge contacting the thecal sac, severe degenerative facet hypertrophy with moderate bilateral lateral recess and foraminal narrowing, mild desiccation, degenerative spondylosis and small annular tear. Spinal sonography of the thoracic spine, lumbar spine and bilateral sacroiliac joints were within normal limits. Electromyography of the right lower extremity from 11/15/04 suggested mild right L4 radiculopathy. Orthopedic evaluation with Dr. on 11/17/08 noted absent ankle reflexes, intact sensation, tenderness and difficulty with heel and toe walking. Dr. did not feel the claimant was a surgical candidate and epidural steroid injections were recommended. The claimant elected to continue conservative treatment and was given Bextra, Soma and Ultram. On 02/23/05 it was noted she could be released to light duty work on an ergonomic chair, foot stool and lumbar pillow were approved. Dr. performed a medical evaluation on 03/29/05 and felt the claimant was at maximum medical improvement and assigned a 10 percent impairment rating. The claimant continued chiropractic management through 05/16/05. She returned to chiropractic care on 01/08/09 for progressively worsening back and bilateral leg pain with notation she had difficulty walking, getting out of a chair and sleeping. Physical examination demonstrated 4/5 bilateral psoas and iliacus strength, positive bilateral Kemp's and spasms. It was felt the claimant had an exacerbation of her work injury and MRI evaluation was recommended to determine the treatment protocol.

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

The reviewer finds that MRI of the lumbar spine is not medically necessary in this female. The notations only recently demonstrate on 01/08/09 that she needed to be wheeled out of the office in a chair. She needed help standing, and she had bilateral psoas and iliacus weakness describes as 4/5. There was no evidence of cauda equina syndrome noted. No radiographs were performed. There has been no evidence of interval trauma noted. She had an MRI on 09/15/04, which does not demonstrate a significant neural compressive lesion. Neither conservative care nor radiographs have been performed prior to undergoing any MR imaging according to the records provided for this review. The reviewer finds that medical necessity does not exist for MRI of the Lumbar Spine.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)