

SENT VIA EMAIL OR FAX ON  
Jun/08/2009

# Applied Resolutions LLC

An Independent Review Organization  
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**DATE OF REVIEW:**  
Jun/08/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Repeat MRI with and without contrast, Lumbar Spine

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**  
Reviewer is Board certified in Family Practice, CAQ in Sports Medicine

**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**

OD Guidelines  
Denial Letters 5/7/09 and 4/22/09  
Clinic 4/29/08 thru 3/17/09  
Radiology Report 6/5/08, 5/4/05, and 4/1/05  
Medical Decision Review 5/23/08  
Medical Decision Review 5/23/08

**PATIENT CLINICAL HISTORY SUMMARY**

The patient was injured in xx-xxxx. One report indicates the injury was from slipping and landing in a splints position, injuring his groin. Another note indicates the patient fell onto his back after slipping on a rack on xx-xx-xx.

Regardless, the patient starting complaining of low back pain in April 2005. He had an MRI of his lumbar spine on 5-4-05 that demonstrated a broad based disc bulge at L3-4 with mild right neuroforaminal narrowing

There are no clinical notes available to the reviewer prior to 2008 (except the first MRI report and a pelvic Xray). The patient was seen by Dr. and then referred to a Neurosurgeon. He was evaluated and an epidural steroid injection was recommended as well as a CT myelogram. The CT was performed on 6/5/08 and demonstrated disc bulges at multiple levels but most significant was the broad based disc bulges seen at L3-4 and L4-5, both with mild left foraminal and moderate right foraminal encroachment. On follow up visit after the lumbar CT, Dr. (neurosurgeon) recommended physical therapy and epidural injections. He

did read the CT and call the disc bulge at L3 a “far lateral disc herniation”. The patient started PT and had an epidural steroid injection on the right. The epidural reportedly helped. By a follow up visit with Dr. in 11/08, the patient’s right-sided pain had resolved and he now complained of left sided back pain. This left sided pain was felt to be mechanical and not disc related in origin. On the last exam provided on 11/22/08, there were no new changes and in fact the exam was normal with respect to strength, sensation, reflexes and a negative straight leg raise in the lower extremities.

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

In this case, the approval being sought is for a Lumbar Spine MRI. In reviewing the case, there is not documentation or evidence that a new study is needed. The patient had an initial MRI in 2005. Later in 2008, he had a CT myelogram of the lumbar spine, which is very specific for disc and nerve root compression. He had the nerve root compression treated with physical therapy and a lumbar epidural steroid injection and his right-sided pain resolved. At some point, he developed or complained of left sided pain. There was no note of a new injury or a new change in his exam or other diagnostic tests to indicate the need for an MRI. The ODG guidelines support this in saying: “Repeat MRI’s are indicated only if there has been progression of neurological deficit”

Therefore, the prior decision not to approve the MRI of the Lumbar spine is upheld.

**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)