

I-Decisions Inc.

An Independent Review Organization
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DATE OF REVIEW:

May/11/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat MRI with and without contrast

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

M.D., board certified in Orthopedic Surgery

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

PATIENT CLINICAL HISTORY SUMMARY

The patient has undergone a two-level lumbar fusion previously. The patient now complains of back pain. There is no evidence of any radiculopathy on the physical examination by the treating physicians. The diagnosis appears to be facet-mediated pain at the junctional level above the fusion. Discogram reveals an abnormal disc at L3/L4 with concordant pain and an annular tear at L3/L4 prior to the time of the decision to undergo the two-level L4/L5 and L5/S1 fusion. The fusion is noted to be solid. There is a previous request for median branch rhizotomies as well as this request for a repeat MRI scan with and without contrast, the sole criteria which appears to be the fact that this patient has not had an MRI scan for some time.

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

This patient is stated to have a junctional pain mediated by the facets at L3/L4. The reasons for the repeat MRI scan are totally unclear. There is no radiculopathy that would justify such a repeat study. The treating physician does not explain why the ODG Guidelines should be set aside in this particular instance. The medical records based upon the physical examination and other studies do not aid this reviewer in finding an explanation as to why this particular patient should have an additional MRI scan in contradiction to the recommendations in the Official Disability and Treatment Guidelines. It is for this reason this reviewer could not overturn the previous adverse determination. The reviewer finds that medical necessity does not exist for Repeat MRI with and without contrast.

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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