Notice of Independent Review Decision

DATE OF REVIEW: 11/12/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI of the Lumbar Spine without Contrast

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

Board Certified in Physical Medicine & Rehabilitation

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

MRI OF THE LUMBAR SPINE WITHOUT CONTRAST - UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- MRI Lumbar Spine, M.D., 01/10/97
- Clinic Note, M.D., 09/26/08, 10/22/08, 11/14/08, 01/05/09, 01/30/09, 02/23/09, 03/23/09, 10/12/09

- Medication Visit, Dr., 04/15/09, 04/20/09, 05/11/09, 06/08/09, 07/02/09, 07/27/09, 08/24/09, 09/17/09,
- Lumbar Intra-articular Steroid Injection, Dr., 09/22/09
- Follow Up, Dr., 09/30/09
- Denial Letter, 10/09/09, 10/16/09
- The ODG Guidelines were provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient underwent an MRI of the lumbar spine, a steroid injection and medication management. His most recent medications included Kadian, Hydromorphone, Medrol Dosepak, Megace and Baclofen.

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

The requested MRI of the lumbar spine is not medically reasonable and necessary.

The Official Disability Guidelines specifically allow for a repeat MRI if there has been progression of neurologic deficit. The physical examination documented by the treating doctor is negative for any radicular symptomatology. The treating doctor has documented that the MRI is being done so that treatment can continue and to "decrease his anxiety." These are not valid rationalizations for the use of advanced imaging. The patient has a longstanding history of stable medical care with rather aggressive doses of narcotics. He has been denied on many occasions any sort of interventional treatments and when he finally did have an interventional treatment, his symptoms actually worsened. As such, an MRI cannot be justified in this case.

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**

- [x] **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- [ ] **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- [ ] **MILLIMAN CARE GUIDELINES**
- [x] **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)**