



## Notice of Independent Review Decision

### **DATE OF REVIEW:**

11/04/2009

### **IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Postoperative lumbar MRI with contrast.

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

Board Certified Chiropractor

### **REVIEW OUTCOME**

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

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.

**The medical necessity for the requested postoperative lumbar MRI with contrast is not established.**

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- TDI/DIVISION OF WORKERS' COMPENSATION Referral form
- 10/20/09 MCMC Referral
- 10/20/09 Notice to Utilization Review Agent of Assignment
- 10/20/09 Notice to MCMC, LLC of Case Assignment
- 10/20/09 Confirmation of Receipt of a Request For a Review, DWC
- 10/19/09 Request For A Review By An Independent Review Organization,
- 10/12/09 Adverse Determination Upheld on Reconsideration letter, RN,
- 10/12/09 report
- 10/12/09 memo from RN
- 10/06/09 memo from Utilization Review/Managed Care Dept.
- 10/05/09 memo from RN
- 10/05/09 report from DC,
- 10/05/09 Preauthorization Determination: Adverse Determination letter, RN
- 10/01/09 memo from Utilization Review/Managed Care Dept.,
- 09/30/09 Letter of Medical Necessity for a post-op MRI, D.C.
- 05/22/09 Operative Report/Procedure, Dr. Hospital
- Note: Carrier did not supply ODG Guidelines.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Records indicate that the injured individual is a female who presented to the office of the attending provider (AP) for examination and treatment of musculoskeletal injuries that reportedly occurred as a result of an occupational injury that was alleged on xx/xx/xx. The history reveals that her injuries were reportedly caused by being struck by the handle of a cart on her back. Conservative care ensued with reported less than desirable results, followed by injections. She eventually underwent extensive lumbar surgery on 05/22/2009. The records reveal that four sessions of post surgical rehabilitation have been completed to date.

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

The records fail to establish the medical necessity for the requested repeat MRI. The submitted documentation does not provide objective or subjective data to suggest that there are significant new deficits that were not present before surgery and furthermore that there are any progressive neurologic deficits. The submitted clinical information neither documents nor reveals any new trauma. Lastly, the injured individual has not participated in a significant course of post surgical course of conservative care to include physical therapy (PT).

The documentation does not reveal the emergence of new symptomatology or objective deficits that were not already and previously a part of the injured individual's symptom picture or that the new MRI has reasonable expectations of altering the current course of care.

This determination is made consistent with the Official Disability Guideline which is silent on repeat post surgical MRI's and Clinical Guideline Tool; Spinal Imaging which states:

First and foremost, regarding any repeat imaging, the clinical data must include evidence that the patient is a potential surgical candidate and is amenable to surgical intervention if warranted by the MRI.

Clinical indicators for repeat diagnostics include:

- Evidence of progressively worsening neurological deficits since the previous study was performed.
- Documented interval changes in subjective and/or objective findings.
- New onset findings or reinjury.
- Documented poor resolution or technique on previous films.
- Results of the previous study are not available.
- For evaluation of possible suspected abscess, infection or reherniation.

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

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

**OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION):** Intracorp Clinical Guideline Tool; Spinal Imaging