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Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 08/04/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI of the lumbar spine

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

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)

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 - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with, M.D. dated 01/26/00, 04/10/00, 06/05/00, 08/28/00, 09/20/00, 10/13/00, 11/13/00, 12/11/00, 01/29/01, 02/21/01, 04/30/01, 05/11/01, 08/13/01, 11/05/01, 04/11/02, 08/01/02, 10/03/02, 03/06/03, 04/17/03, 07/10/03, 12/04/03, 03/04/04, 08/25/05, 10/31/05, 01/06/06, 03/09/06, 06/22/06, 09/12/06, 12/01/06, 03/01/07, 05/10/07, 06/28/07, 02/21/08, 05/22/08, 08/07/08, 08/25/08, 09/18/08, 04/09/09, 05/14/09, 08/06/09, 01/28/10, and 06/10/10

Evaluations with, M.D. dated 02/24/04, 01/31/06, 02/21/06, and 03/07/06

Procedure notes from Dr. dated 05/04/04 and 05/18/04

An evaluation with, M.D. dated 01/17/05

X-rays of the lumbar spine interpreted by, M.D. dated 08/25/05

A letter of authorization for a lumbar MRI from, L.P.N. dated 09/13/05

An MRI of the lumbar spine interpreted by, M.D. dated 09/23/05
Evaluations with, M.D. dated 11/01/06 and 11/09/06
Laboratory studies dated 11/01/06
A cardiolute study interpreted by, M.D. dated 11/09/06
An EKG report interpreted by Dr. dated 11/09/06
An operative report from Dr. dated 11/22/06
A physical therapy evaluation with an unknown therapist (signature was illegible) dated 01/24/07
Physical therapy daily notes from, P.T.A. dated 01/29/07, 01/31/07, 02/01/07, 02/05/07, 02/07/07, 02/12/07, 02/14/07, 02/20/07, 02/21/07, 03/16/07, 03/21/07, 03/23/07, 03/26/07, 03/28/07, 04/03/07, 04/04/07, 04/12/07, and 04/20/07
Progress summaries from Ms. dated 02/21/07 and 04/04/07
An MRI of the lumbar spine interpreted by, M.D. dated 06/21/07
A Required Medical Evaluation (RME) with, M.D. dated 11/14/07
A letter of non-certification for a lumbar MRI, according to the Official Disability Guidelines (ODG), from, M.D. dated 05/12/10
A letter of non-certification for a lumbar MRI, according to the ODG, from, M.D. dated 06/10/10
A carrier submission for a lumbar MRI from at the Law Offices of dated 07/21/10
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On 01/26/00, Dr. recommended a Medrol Dosepak, Celebrex, physical therapy, and a possible lumbar epidural steroid injection (ESI). On 08/28/00, Dr. recommended a Functional Capacity Evaluation (FCE), Vioxx, and a home neurostimulator unit. On 12/11/00, Dr. requested a MED procedure. On 02/21/01, Dr. noted the claimant was one month status post decompressive laminotomy in the lumbar spine. Dr. requested an impairment rating on 08/13/01. X-rays of the lumbar spine interpreted by Dr. on 08/01/02 showed mild L5-S1 disc space narrowing and spondylolisthesis and physical therapy was recommended. On 04/17/03, an MRI of the lumbar spine was reviewed and showed an L4-L5 moderate disc protrusion and a moderate L4-L5 herniated nucleus pulposus. Lumbar ESIs, lysis of adhesions, and trigger point injections were performed by Dr. on 05/04/04 and 05/18/04. X-rays of the lumbar spine interpreted by Dr. on 08/25/05 showed multilevel degenerative changes and grade I anterior spondylolisthesis at L4-L5. An MRI of the lumbar spine on 09/23/05 showed moderate facet joint arthrosis with subluxation of L4 on L5 and an annular disc bulge, as well as a 3 mm. residual disc bulge with segmental instability at L5-S1. A lumbar ESI and trigger point injections were performed by Dr. on 03/07/06. On 11/22/06, Dr. performed a redo L4-L5 hemilaminotomy, redo L4-L5 medial facetectomy with L5 foraminotomy and subarticular decompression/neurolysis, and an L4-L5 disc space exploration/decompression. Physical therapy was performed with Ms. from 01/29/07 through 04/20/07 for a total of 18 sessions. On 03/01/07, Dr. performed a right trochanteric bursa injection and recommended Neurontin. On 11/14/07, Dr. recommended ongoing office visits every four to six months and a home exercise program. An MRI of the lumbar spine on 06/21/07 showed postoperative changes at L4-L5 with disc bulges at L4-L5 and L5-S1. On 09/18/08, Dr.

performed a right hip joint injection and requested an MRI. On 05/14/09 and 01/28/10, Dr. recommended another lumbar MRI. On 05/12/10, Dr. wrote a letter of non-certification for the lumbar MRI. On 06/10/10, Dr. again requested the lumbar MRI. A letter of non-certification for the lumbar MRI was provided by Dr. on 06/10/10.

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

In my opinion, based upon the ODG, the requested MRI of the lumbar spine is neither reasonable nor necessary. Dr.'s documentation indicates the claimant has some weakness and numbness in the L5 distribution. It appears to have been present since the time of her last laminectomy. She had a post laminectomy MRI that demonstrated no change. She has had subsequent radiographs that indicate no change. It should be noted that these were not flexion extension films and there is no evidence of instability presented. Therefore, in my opinion, the MRI of the lumbar spine is neither reasonable nor necessary. The previous adverse determinations should be upheld.

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 AND KNOWLEDGE BASE
- 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)