

Becket Systems

An Independent Review Organization
13492 Research Blvd. Suite 120-262
Austin, TX 78750-2254
Phone: (512) 553-0533
Fax: (207) 470-1075
Email: manager@becketsystems.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/29/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar 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 Orthopedic Surgeon

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

Official Disability Guidelines

Dr. office notes 02/15/08, 02/26/08, 03/04/08, 03/17/08, 03/26/08, 4/9/08, 07/14/09, 07/28/09, 08/11/09, 09/08/09, 10/06/09, 11/03/09, 12/01/09, 01/04/10, 01/18/10

Referral request 07/14/09

Adverse Determinations, 09/21/10, 10/05/10, 10/07/10

Peer review reports 06/14/10, 09/20/10, 10/06/10

Dr. office notes 06/01/10, 06/10/10, 08/25/10,

MRI appointment form

correspondence 09/21/10, 10/05/10

Lab report, undated

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a xx, with a low back injury on xx/xx/xx when he was off loading his trailer, pushing a car, and felt a sharp pain in his low back. X-ray of the lumbar spine on 02/20/08 showed loss of disc height at L5-S1 and some degenerative changes at the L5 vertebral body. The claimant was diagnosed with lumbar and thoracic sprain/strain, low back pain and muscle spasms. He was treated with physical therapy, NSAIDS, and off work. The claimant improved with conservative treatment and was released to work full duty on 04/09/08.

The claimant returned to the physician on 07/14/09 with a recurrence of the back pain that he was having back in 2008. He had not been seen since 04/09/08 but had noted over the previous several months that his low back pain had been increasing. He denied any new

injury. He noted that he had modified his job, that he was no longer. On exam the claimant had two plus reflexes and full strength. Straight leg raise was negative. The claimant was tender over the lumbar spine with tenderness over the facets and paraspinals. He had restricted lumbar range of motion and increased pain with extension. The diagnosis was low back pain and lumbar facet syndrome. X-rays at that time showed loss of disc height at L5-S1 and degenerative changes in the L5-S1 disc space; there were sclerotic endplates inferior L5/superior S1 with spurring and lipping anteriorly. Given the majority of his pain being axial and increased with facet loading, the physician recommended facet injections. The claimant was placed on tramadol, Norco, and Mobic and modified duty.

The claimant followed up monthly with Dr. with essentially no change. Facet injections were denied by the insurance carrier. Records indicated that a Designated Doctor Evaluation was done in December 2009. At the 01/04/10 office visit the claimant complained of worsening low back pain with bilateral lower extremity pain and numbness. There was discoloration at the distal tip of the left great toe and decreased sensation in the left L5-S1 dermatome. On 01/18/10 the claimant continued to describe numbness in the left lower extremity.

The records lapse until 06/01/10 when the claimant was treating with Dr., physical medicine and rehab, for back pain. His note on 06/01/10 described decreased lumbar range of motion. A lumbar MRI was ordered. On 06/10/10 the claimant was noted to have back pain; left leg pain and numbness; and toe numbness. He had decreased strength on the left and decreased sensation in the great toe. The diagnosis was questionable radiculopathy L5-S1. An MRI was again ordered. The study was denied on peer review. Dr. note of 08/25/10 noted only decreased lumbar range of motion. MRI was again denied on peer reviews dated 09/20/10 and 10/06/10.

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

The MRI of the lumbar spine with and without contrast is not medically necessary. These records do not reflect that non-operative conservative care for the lumbar spine complaints have been documented within the records. Non-operative care previously was documented in 2008 and 2009 but none has been documented recently. Therefore, proceeding with the MRI is not medically necessary according to ODG criteria. There is no evidence of progressive neurologic deficit on examination.

Official Disability Guidelines Treatment in Worker's Comp, 15th edition, 2010 Updates. Low Back:

Lumbar MRI

Recommended for indications below. There is support for MRI, depending on symptoms and signs, to rule out serious pathology such as tumor, infection, fracture, and cauda equina syndrome. Patients with severe or progressive neurologic deficits from lumbar disc herniation, or subjects with lumbar radiculopathy who do not respond to initial appropriate conservative care, are also candidates for lumbar MRI to evaluate potential for spinal interventions including injections or surgery

Indications for imaging -- Magnetic resonance imaging

- Lumbar spine trauma: trauma, neurological deficit
- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit.

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)