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Notice of Independent Review Decision

DATE OF REVIEW: December 15, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI lumbar spine w/o & w/dye

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

This physician is a Board Certified Neurosurgeon with 47 years of experience.

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

On xx/xx/xx, the claimant was evaluated by DC. He has received conservative care, lower levels medication, physical therapy, imaging, and eventually surgery performed by Dr. to his L5/L5 and L5/S1 spine. He developed chronic pain

syndrome, radiculopathy into his bilateral lower extremities and erectile dysfunction. He as numbness, tingling and weakness in the bilateral lower extremities. Impression: Failed back syndrome.

On November 9, 2010, the claimant was evaluated by M.D. He has continued to work full time; he does not like to take his medications. His chief complaint is back pain and bilateral leg pain. Physical examination shows a well healed midline incision, positive extensor lag, positive sciatic notch tenderness bilaterally, positive flip test bilaterally, positive Lasegue's by 45 degrees, equivocal Bragard's, weakness of gastro-soleus bilaterally, paresthesias in the S1 nerve root distribution bilaterally and L5 nerve root distribution on the left. Dr. recommended an MRI of the lumbar spine.

On November 22, 2010, M.D. a physical medicine and rehabilitation physician, performed a utilization review on the claimant. Rational for Denial: There are no acute focal neurological deficits reported and no acute injury to support the request. Injured worker with chronic low back pain and subjective sensory changes with to appreciation of acute progressive focal neurological deterioration to the lower extremities. Therefore, it is not certified.

On December 1, 2010, M.D., P.A., a neurosurgeon, performed a utilization review on the claimant Rational for Denial: The patient is status post L4-5, L5-S1 instrumented arthrodesis with pedicle screws and rods with no interbody support. He complains of low back pain and bilateral leg pain. No previous imaging studies were submitted for review. There is no evidence of progression of neurologic deficit, and medical necessity is no established. Therefore, it is not certified.

PATIENT CLINICAL HISTORY:

On xx/xx/xx, the claimant injured his lumbar spine from an unknown mechanism of injury.

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

The previous decisions are upheld as there is no evidence of progression of neurologic deficit and no previous imaging studies were submitted for review.

Per the ODG Low Back Chapter:

MRI's are rest of choice for patients with prior back surgery. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology.

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**
- ☐ **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)