



Notice of Independent Review Decision

DATE OF REVIEW: 01/18/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat MRI Scan of the Lumbar Spine

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

Board Certified in Neurological 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.

Repeat MRI Scan of the Lumbar Spine - UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Lumbar Spine X-rays, M.D., 03/31/09
- Left Hip X-rays, M.D., 03/31/09
- MRI of the Lumbar Spine, M.D., 05/11/09
- Encounter Summary, M.D., 06/08/09, 07/20/09, 09/21/09, 11/03/09
- Utilization Review Referral, Dr., 11/06/09
- Denial Letter, 12/18/09

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient complained of back and leg problems. He has undergone x-rays of the lumbar spine and left hip. An MRI of the lumbar spine was performed as well, which revealed a

posterior disc bulge at L5-S1, which impinged on the left S1 nerve. He has undergone physical therapy with not much benefit. He was not reported to be on any medications, but has undergone one Epidural Steroid Injection (ESI).

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

No, the repeat MRI scan of the lumbar spine is not medically reasonable or necessary. This patient neurologically is unchanged. He received some relief from the epidural steroid injection. According to ODG criteria for MRI scanning, this case does not meet the criteria for a repeat scan, as there is no change in neurological function, which includes reflex, sensory, and motor testing. There are some subjective changes in complaints, but no objective findings. Based on this, the request for a repeat MRI scan of the lumbar spine does not meet the necessary criteria.

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)