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Notice of Independent Review Decision

DATE OF REVIEW: 5/7/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a lumbar MRI (72148).

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. This reviewer has been practicing for greater than 15 years.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a lumbar MRI (72148).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Back Institute and Health Care

These records consist of the following (duplicate records are only listed from one source):
Records reviewed from Back Institute: Patient Information – 3/10/10, MRI Request – 3/8/10, Follow-up Notes – 12/15/05-4/1/10, Office Note – 10/29/07; MD MRI Report – 3/25/08; MD

MRI report – 1/5/04; MD Operative Report – 9/19/08 & 2/20/09; Epidural Pain Scale – 9/19/08; MD Operative Report – 2/9/07.

Records reviewed from Health Care: Denial letters – 3/12/10 & 3/26/10; MD letter – 3/23/10.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient has a history of back problems dating back to some sort of injury. The date of injury referred to in the medical record indicates that there was another injury, apparently to the lower back. Most of the medical record presented for my review discusses issues related to the cervical spine.

To summarize the low back issues, records from M.D. indicate that there was an injury to the lower back. The injured worker was apparently treated for sacroiliac joint dysfunction. The treatment was initially effective in controlling symptoms.

A MRI of the lumbar spine showed multilevel spondylosis without disk herniation, spinal stenosis, or neural foraminal narrowing. An L3 vertebral body lesion, probably an atypical meningioma, was also identified.

Available records first mention low back pain. In November, 2006, there was a mention of “recurrence” of the sacroiliac joint pain. In February, 2007, sacroiliac joint injections resulted in 70% improvement. Neurologically, the patient was said to be intact in February, 2009. In March, 2009, the patient was complaining of lower back pain and had positive straight leg raising testing on the right. Low back pain was mentioned in July, 2009. Straight leg raising was negative at that time and Patrick’s maneuver was said to be positive. No neurologic deficits were described at that time.

The most recent mention of her lower back problems was dated. Dr. indicated that the pain was as bad as it had ever been since her injury and she was having difficulty sleeping because of pain. The pain was radiating from the lower back to the right groin and lateral leg. There was associated tenderness at the L5-S1 level on the right. Flexion and extension of the lumbar spine were said to be uncomfortable. For the first time, a decreased patellar reflex was noted on the right. There was a sensory deficit over the right lateral thigh. Straight leg raising was positive at 40° on the right and straight leg raising on the left caused cross-over pain to the right lower back. There was no tenderness over the right hip.

Dr. at that time mentioned that the injured worker was taking Lortab and Oxycodone, but was out of the Topomax and Lyrica which had been previously prescribed for chronic pain. Dr. indicated that he had ordered a MRI of the lumbar spine because the injured worker was now demonstrating neurologic deficits which had gotten worse and which were not present in July, 2009. He felt that she had severe pain requiring Topomax, Lyrica, and Dilaudid and he also noted that her neurologic deficit was progressive. He stated that he had thought initially that her problem was a sacroiliac joint dysfunction, but her symptoms in March, 2010 were more radicular than related to sacroiliac joint dysfunction.

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

Medical records available for review indicate that this worker sustained some sort of injury to her lower back. There is also reference of another injury although there is no description of that injury or clinical findings at that time. Records indicate that the injured worker was treated successfully for sacroiliac joint dysfunction with injections. She had concurrent, severe neck problems with cervical radiculopathy which required aggressive treatment with medications, chiropractic treatment, and epidural steroid injections.

There are intermittent mentions of lower back discomfort throughout the medical record reviewed, but the most impressive information in the medical record was reported on xx/xx/xx when the injured worker's symptoms appeared to support the diagnosis of a radiculopathy and the treating physician, Dr., described progressive neurologic deficits in addition to severe pain which interfered with her sleep and required narcotics in addition to Topomax and Lyrica for control.

The ODG Guidelines indicate that repeat MRIs are indicated only if there has been a progression of neurologic deficits. The Guidelines further state that "patients with severe or progressive neurologic deficits and lumbar disk 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." The Guidelines further state that for uncomplicated low back pain with radiculopathy, an MRI is indicated after at least one month of conservative therapy OR SOONER if severe or progressive neurologic deficit is present.

This individual had an MRI of the lumbar spine performed in January, 2004 and this demonstrated multilevel spondylosis, but no evidence of neural foraminal compromise, spinal stenosis, or disk herniation. The treating physician on 03/08/2010 documented that the individual was experiencing severe pain in the lower back with right lower extremity symptoms and progressively increasing neurologic deficits consistent with a radicular process. This does constitute a symptom complex and physical findings which would support the medical necessity for a repeat MRI of the lumbar spine. The requested procedure is medically necessary.

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)