

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/04/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat lumbar MRI without contrast

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

MD, 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

9/17/10, 9/24/10

M.D. 9/16/10

Orthopaedic Specialists 9/3/10 to 9/13/10

M.D. 9/24/10

Pain Associates 11/5/09, 4/29/10

Orthopaedic Group 1/27/09 to 7/16/09

Surgical Hospital 8/20/09 to 10/23/07

Radiological Association 4/29/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who sustained a work related injury to his low back on xx/xx/xx when he fell out of an that was on the ground while working on it. An MRI of his lumbar spine on revealed that there was no compression fracture or traumatic subluxation, but there was a disc bulge at L4-5, more prominent on the right. There were also bilateral annular tears. There was no mechanical compression of the L4 nerve root. There was degenerative disc narrowing and shallow disc protrusion that did not depress the thecal sac or descending S1 nerve roots. The claimant had another MRI of his lumbar spine on 08/20/08 that showed no significant change in the MRI appearance of the lumbar spine when compared to the prior exam of 10/23/07. There was distal lumbar facet arthrosis without significant foraminal compromise, concentric disk bulge L4-5, more prominent on the right, with associated annular tears. There was a shallow broad-based disc protrusion at L5-S1. There was no descending or exiting nerve root impingement in neutral spine position. When the claimant saw Dr. on 11/05/09 he complained of bilateral low back pain that occasionally radiated into his posterior thighs. He had numbness in his calves and tops of his feet bilaterally. Dr. noted that the claimant had received epidural steroid injections and facet joint injections, which did

not help. He had taken anti-inflammatories and received physical therapy without benefit. Dr. recommended a discogram. The lumbar discogram was done on 04/29/10 and was negative for concordant pain reproduction at the L3-4 disc level. It was negative for concordant pain reproduction with degenerative changes at the L4-5 disc level and was positive for concordant pain reproduction with degenerative changes at the L5-S1 disc level. A CT scan done following the discogram revealed diffuse L3-4 disk degeneration. There were grade IV annular tears at L4-5 related to the left foramen and right lateral foramen though a right posterolateral approach was used and the right-sided finding may have been spurious. There was a grade IV midline L5-S1 annular tear associated with a midline disc protrusion.

The claimant saw Dr. on 09/03/10 and complained of constant stabbing and sharp pain rated as 6/10 that radiated into both legs. On examination he had diffuse tenderness to the spinous process, moderate bilateral lumbar paravertebral muscle spasm, negative straight leg raising and a mildly positive Lasegue's on the left side. Dr. recommended a repeat MRI as it had been more than 18 months since the last one. He noted that the claimant had failed conservative treatment and would probably need a fusion at L5-S1. The request for a repeat MRI was denied by two peer reviews dated 09/17/10 and 09/24/10 as the claimant had had a lumbar CT along with the discogram in April 2010. Also, the claimant's physical examination was essentially normal with no evidence of instability. There were no significant changes when the 08/20/08 MRI was compared to MRI of 10/23/07.

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

The MRI of the lumbar spine without contrast is not medically necessary. On 04/29/10 a CT scan of the lumbar spine following discogram was performed. There is no reason why an MRI would be necessary at this present time. There is not any indication of a change in the clinical condition, which would warrant additional diagnostic studies in the form of an MRI. The reviewer finds that medical necessity does not exist for Repeat lumbar MRI without contrast.

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

Indications for imaging -- Magnetic resonance imaging

- Thoracic spine trauma: with neurological deficit
- Lumbar spine trauma: trauma, neurological deficit
- Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit
- Uncomplicated low back pain, suspicion of cancer, infection, other "red flags"
- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. (For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.) (Andersson, 2000)
- Uncomplicated low back pain, prior lumbar surgery
- Uncomplicated low back pain, cauda equina syndrome
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, painful
- Myelopathy, sudden onset

- Myelopathy, stepwise progressive
- Myelopathy, slowly progressive
- Myelopathy, infectious disease patient
- Myelopathy, oncology patient

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)