

SENT VIA EMAIL OR FAX ON
Oct/15/2010

IRO Express Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: (817) 349-6420

Fax: (817) 549-0310

Email: resolutions.manager@iroexpress.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/15/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat MRI Lumbar Spine w/wo Contrast and Repeat MRI Cervical Spine w/o Contrast

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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

OD Guidelines

Denial Letters 8/3/10 and 9/2/10

9/28/10

OP Report 4/27/07

Dr. 2/1/07 thru 8/23/10

MRIs 9/2/08, 1/23/07, 2/10/10

PATIENT CLINICAL HISTORY SUMMARY

This is a male with a date of injury , when he was pushing a heavy piece of metal off a table. He is status post ACDF at C6-C7 on 04/27/2007. He also underwent an anterior lumbar fusion at L5-S1. He states he is unable to walk on the heel or toes of his left foot. His examination on 07/26/2010 reveals that the left thigh is smaller than the right thigh. A cervical MRI 09/02/2008 revealed multilevel cervical spondylosis, greatest at C6-C7, where there is a moderate spinal canal stenosis and moderate-to-severe right foraminal narrowing and severe left foraminal narrowing. There is multilevel mild spinal canal stenosis. At C3-C4

and C5-C6 there is moderate foraminal narrowing. There is moderate right foraminal narrowing at C2-C3 and C4-C5. An MRI of the lumbar spine 02/10/2010 reveals postoperative changes at L5-S1. There is moderately severe biforaminal stenosis. At L3-L4 there is some facet arthrosis and ligamentum hypertrophy with no canal or foraminal stenosis. The provider is requesting a repeat MRI of the lumbar spine with and without contrast and a repeat MRI of the cervical spine without contrast.

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

The MRI of the lumbar spine and cervical is not medically necessary. According to the ODG, "Low Back" chapter, serial MRIs are indicated only when there is progression of neurological deficits. There is no evidence that the claimant has any progression of neurological deficits or has had any significant change in his symptoms since the last MRI. No specific deficits related to the cervical spine are detailed. Moreover, he had a recent MRI of the lumbar spine, and it is not apparent why this needs to be repeated. In this case, there is very little to suggest, by examination or by history that the claimant is suffering from new or progressive neurologic deficits that warrant additional neuroimaging. Further insight is needed as to why a repeat MRI is medically necessary and how this will impact his care.

References/Guidelines

ODG "Low Back" chapter

MRI

Indications for imaging -- Magnetic resonance imaging (MRI):

Repeat MRI's are indicated only if there has been progression of 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)