

Notice of Independent Review Decision

**PEER REVIEWER FINAL REPORT**

**DATE OF REVIEW:** 9/22/2010  
**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

MRI of Lumbar Spine

**QUALIFICATIONS OF THE REVIEWER:**

Family Practice

**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)

MRI of Lumbar Spine Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Office visit by MD dated 9/14/2010
2. Fax page dated unknown
3. Notice to air analyses by dated 9/9/2010
4. Fax page dated 9/8/2010
5. IRO request form by author unknown, dated 9/8/2010
6. Request form by author unknown, dated 9/7/2010
7. Letter by dated 8/31/2010
8. Letter by dated 8/24/2010
9. Letter by dated 8/10/2010
10. Fax page dated 9/10/2010
11. Letter by dated 9/10/2010
12. Notice to air analyses by dated 9/9/2010
13. Notice to utilization review by, dated 9/9/2010
14. Fax page dated 9/8/2010
15. IRO request form by author unknown, dated 9/8/2010
16. Request form by author unknown, dated 9/7/2010
17. Letter by dated 8/31/2010
18. Work status report by author unknown, dated 8/30/2010
19. Office visit by MD, dated 8/30/2010
20. External review by MD, dated 8/25/2010

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21. Letter by dated 8/24/2010
22. Letter by MD, dated 8/16/2010
23. Office visit by MD, dated 8/13/2010
24. Letter by dated 8/10/2010
25. External review by MD, dated 8/10/2010
26. Office visit by MD, dated 8/6/2010
27. Phone message by MD, dated 8/4/2010
28. Office visit by MD, dated 8/3/2010
29. Initial visit by MD, dated 8/20/2009
30. Letter by MD, dated 6/25/2009
31. Note by MD, dated 6/25/2009
32. Care activity report by author unknown, dated 6/12/2009
33. Letter by MD, dated 4/28/2009
34. Note by MD, dated 4/28/2009
35. Letter by author unknown, dated 4/21/2009
36. MRI lumbar spine by MD, dated 4/4/2009
37. CT lumbar spine by MD, dated 3/30/2009
38. CT cervical spine by MD, dated 3/30/2009
39. Ribs uni right and PA and lateral chest by MD, dated 3/14/2009
40. Fax page dated unknown
41. Utilization review request by author unknown, dated unknown

#### **INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

The injured employee is a male whose date of injury isxx/xx/xx. Records indicate the injured employee was injured when he fell off a ladder and landed on his right side. MRI of the lumbar spine dated 04/04/09 revealed a mild circumferential annular bulge at L4-5 with mild facet arthropathy. The central canal is patent at this level. There is mild bilateral neural foraminal stenosis demonstrated. At L5-S1 there is disc desiccation with a moderate circumferential annular bulge. Superimposed on this is a small broad based left paracentral disc protrusion. Moderate facet arthropathy also was noted. There is early mass effect on the left lateral recess, and moderate bilateral neural foraminal stenosis demonstrated. The injured employee was seen in follow-up for neurosurgical consultation on 04/21/09. CT and MRI of the lumbar spine were reviewed and noted to show only right L2 transverse process fracture and L5-S1 disc bulge. The injured employee was noted to have only back pain, and surgery was not recommended with only conservative treatment to include physical therapy and pain management. The injured employee continued to complain of low back pain, and physical therapy was noted to provide no pain relief. Tramadol has helped. Examination performed 08/20/09 reported tenderness to palpation to right upper back. There is negative straight leg raise, 2+ deep tendon reflexes, sensation intact, and no clonus. A request for MRI of the lumbar spine was reviewed on 08/10/10 by M.D. Dr. determined the request for lumbar MRI was not indicated as medically necessary as the history and documentation did not objectively support the request for repeat MRI. The most recent physical therapy notes available for review were dated about a year ago and there was no documentation the injured employee has been exercising on a regular basis. There were no clearly documented objective neurologic deficits or findings of significant dysfunction for which a repeat study could be supported as reasonable and appropriate. Dr. noted that ODG guidelines provide that repeat MRIs are only indicated if there has been progression of neurologic deficit.

A reconsideration / appeal request was reviewed on 08/25/10 by M.D. Dr. noted the injured employee had previous imaging studies which revealed a broad based disc bulge at L5-S1 and nondisplaced fracture of the right transverse process of L2. Dr. noted the injured employee did not have any progression of neurologic deficits that are specified in the records provided. He further noted that a detailed neurologic examination was not specified in the records. There were no red flags identified and no evidence of pathology including cancer, infection or other red flags. As such, the appeal request for MRI of lumbar spine was determined as not medically necessary.

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

Based on the clinical information provided, the request for MRI of the lumbar spine is not recommended as medically necessary. The injured employee is noted to have sustained an injury secondary to a fall on xx/xx/xx. The injured employee underwent lumbar MRI as well as CT scan of the lumbar spine on 04/04/09. These studies revealed broad based disc protrusion at L5-S1 and nondisplaced fracture of the right transverse process of L2. Neurosurgical consult follow-up on 04/21/09 reviewed findings on CT and MRI of the lumbar spine. It was noted the injured employee has back pain only and surgery was not recommended. The injured employee was treated conservatively with physical therapy without significant improvement. Follow-up examination on 08/20/10 revealed no neurologic deficit with negative straight leg raise, 2+ deep tendon reflexes, and sensation intact. There was no evidence of

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motor weakness. As noted on previous reviews, the injured employee had no evidence of progression of neurologic deficit and no red flags identified. As such, the previous denials of MRI of lumbar spine should be upheld as medically necessary and is not established per ODG guidelines.

A supplemental office visit note dated 09/14/10 was submitted for review. Examination on this date noted painful ROM; tender lumbar spinal column; no CVAT; lumbar paraspinous muscle tenderness; positive straight leg raise test L>R; no clonus; sensation intact with monofilament over feet; 2+ DTRs; negative axial load test. This does not change the determination.

**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)