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**Notice of Independent Review Decision**

**DATE OF REVIEW:** 8/30/2010

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of a repeat lumbar MRI scan.

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

The reviewer is a Medical Doctor. The reviewer has been practicing for greater than 10 years in this field.

**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 agrees with the previous adverse determination regarding the prospective medical necessity of a repeat lumbar MRI scan.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
and.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: injured worker information sheet (undated), patient profile 7/13/10, follow up reports from 8/5/10, 7/13/10 consultation report by, 7/13/10 radiology report, 3/30/10 neurodiagnostic report by, MD, 3/12/09 lumbar MRI report, patient information sheet by, DC, 6/7/10 letter by Dr. and 1/27/10 initial narrative by Dr..

: 3/31/10 preauth request, 3/31/10 patient face sheet, 7/13/10 script for MRI, 2/23/10 report by, MD, 8/12/09 neurodiagnostic report and 1/12/09 right shoulder MRI report.

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

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant had been involved in a rollover truck accident. Low back pain complaints led to an MRI dated 3/12/09 that denoted a large disc protrusion, bilateral foraminal stenosis and nerve root impingement at L4-5. Recurrent low back pain with lower extremity radiation has been noted. Right-sided strength has been noted to be 4+/5 with symmetrical decreased reflexes and intact sensation.

Denial letters reflected a lack of progressive neurologic deficit. On 8/5/10, Attending Physician records denoted that a repeat MRI would be to assess if the disc herniation previously noted had progressed. A right S1 and left L5 radiculopathy had been previously noted on electrical studies dated 3/30/10. This was noted to "clearly follow the path of his deficit on the right leg.." The "possibility of an old pars defect" had been noted on x-rays of the lumbar spine from 7/13/10. The claimant was felt to have failed non-operative treatment.

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

Applicable guidelines support a consideration for a repeat MRI in cases of significant neurologic deficit progression and/or post surgical intervention. Neither of these is evident in the claimant's clinical condition and a repeat MRI would be essentially redundant at this time and therefore not medically necessary.

Reference: ODGuidelines

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.)
- 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- 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)