SENT VIA EMAIL OR FAX ON
Mar/30/2011

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Mar/30/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar MRI with and without

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

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
1. Utilization review determination 01/26/11 regarding non-certification lumbar MRI with and without
2. Utilization review reconsideration / appeal request determination 02/16/11 regarding non-certification lumbar MRI with and without
3. Clinical records M.D. 05/04/05-03/04/11
4. MRI right knee 11/22/09
5. MRI lumbar spine 10/06/08
6. Lumbar myelogram with post CT scan 08/10/07
7. Procedure report 12/02/08 regarding right L3-4 transforaminal epidural steroid injection
8. Procedure report 10/24/06 cancelled surgery due to infected buttock boil
9. Procedure note 01/24/06 regarding bilateral L4-5, L5-S1 facet rhizotomy
10. Procedure report 10/11/05 regarding bilateral L4-5, L5-S1 facet injection
11. Procedure report 09/01/05 regarding bilateral L4-5, L5-S1 facet injection
12. Procedure report 07/14/05 regarding bilateral L4-5, L5-S1 facet injection

13. Procedure report 06/30/05 regarding right L4-5 transforaminal epidural steroid injection

PATIENT CLINICAL HISTORY SUMMARY

The patient reportedly was injured when she slipped off a ladder landing on her buttocks. The patient complains of significant low back pain with bilateral lower extremity pain right greater than left. After failing a course of conservative treatment including multiple injections, therapy, and medications, the patient underwent lumbar decompression and instrumented fusion L4-S1. The patient was seen in 10/10 having not been seen since 06/10. The patient states she has been battling with multiple forms of IV antibiotics as she has required osteomyelitis of the left great toe after having toenail removed. During this period of time the lumbar pain escalated and has been limiting her activities. Pain is radiating into both buttock regions. Physical examination reported the patient stands from seated position with guarded movement. Lumbar spine also has guarded movement, exacerbation on both flexion / extension. There is tenderness of paraspinous muscles of lumbosacral region. The lower extremities have some hyperesthesia on right anterior thigh with decreased sensation along the left posterior and lateral lower leg. Straight leg raise is positive bilaterally with diminished right patellar and right Achilles reflex. There is negative bilateral Patrick's. The patient was seen in follow-up on 01/07/11 with complaints of low back pain. Physical examination reported bilateral lower extremities neurologically intact except for decreased sensation along the anterior right thigh; Achilles reflex is diminished on the right. It was noted the last lumbar MRI was from 10/06/08. The patient was recommended to undergo lumbar MRI with and without contrast to evaluate her spinal canal.

A utilization review determination dated 01/26/11 by Dr. recommended non-certification for the request of lumbar MRI with and without contrast. Dr. noted the patient complains of low back pain per medical report dated 01/07/11. Physical examination revealed the patient was able to bend forward to the ankle with some discomfort, bilateral lower extremities are neurologically intact except decreased sensation on anterior right thigh, and Achilles reflexes are diminished on right. Dr. noted that per guidelines repeat MRI is not routinely recommended and should be reserved for significant change in symptoms and / or findings suggestive of significant pathology such as tumor, infection, fracture, neuro compression or recurrent disc herniation. Dr. noted there was no documentation of such findings in the reviewed report. Furthermore, Dr. noted that the patient showed functional improvement with no neurologic deficit. There was also limited documentation of therapy progress report submitted for review to validate sufficient conservative treatment with therapy and optimized pharmacological treatment. Accordingly, Dr. noted the request for repeat lumbar MRI with and without contrast is non-certified.

A reconsideration / appeal request was reviewed by Dr. on 02/16/11, and Dr. determined the request to be non-certified. Dr. noted that per medical report dated 02/04/11 the patient complains of constant lumbar pain. On physical examination the lumbar spine has guarded position that exacerbates on flexion, rotation and extension. Lower extremities have decreased sensation throughout the entire right leg with positive right straight leg raise test. Dr. noted there was no official result of previous imaging studies. He further noted there was no clear documentation of conservative treatment. As such, the request was not substantiated at this time.

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

Based on the clinical information provided, medical necessity is not established for the requested lumbar MRI with and without contrast. Records indicate the patient sustained an injury to low back in XX/XX. She subsequently underwent 2-level lumbar fusion L4-S1. The patient presented with complaints of low back pain. Physical examination reported bilateral lower extremities neurologically intact except for decreased sensation along the anterior right thigh and diminished Achilles reflex on right. These findings are chronic and no indication of new or changed clinical condition. According to the documentation, plain radiographs

revealed solid fusion with no evidence of hardware failure or lucency. Official Disability Guidelines note that repeat MRI is not routinely recommended and should be reserved for significant change in symptoms and / or findings suggestive of significant pathology. There is no evidence of significant change in symptoms or findings suggestive of significant pathology. There is no evidence of motor deficit. The reflex and sensory changes noted on 01/07/11 were chronic findings. As such, the proposed MRI with and without contrast is not supported as medically necessary. It therefore appears the previous reviewers correctly determined the request to be non-certified and should be upheld on IRO.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)