



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 8/10/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a repeat lumbar MRI w/o contrast (72148).

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

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 w/o contrast (72148).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Ins. and Neurosurgery Center

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Ins.: Denial letters – 6/30/11 & 7/14/2011; Denial Letter – 6/30/11; Diagnostic Ctr Lumbar MRI report – 2/15/10, Lumbar CT report – 3/24/11, FL Lumbar Myelogram – 3/24/11; MD Consultation Note - 3/12/10, Follow-up Note – 4/11/11; MD Office Visit note – 1/7/11; MD DDE report – 1/27/11; MD Consultation Note – 6/9/11; and Medications List.

Records reviewed from Neurosurgery Center: MD PT Reassessment – 6/7/11, Follow-up Note – 12/9/10; and Spine and Rehabilitation Center note – 5/4/11.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The has a history of back pain with sciatica. The 2/15/10 dated lumbar MRI reflected a herniated disc at L4-L5. Attending Physician's records included notes from 6/9/11. A 3/24/11 dated CT/myelogram denoted a disc extrusion at L4-5 with possible impingement of the left L5 traversing nerve root. The record also noted that electrodiagnostics have revealed bilateral L4,L5 and S1 radiculopathy. On 1/7/11, however, the electrical study of the lower extremities was noted to have been normal. On 1/27/11, the designated doctor evaluation was noted to reveal a normal neuro. exam, along with breakway weakness of the right leg. Prior treatments have included medications, therapy and ESIs. Improvement was noted in the 6/7/11 dated therapy record. Denial and appeal letters were reviewed.

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

There has not been recent documentation of either a clinical worsening of the claimant's neurological exam or that the claimant has undergone surgical intervention. Neither myelopathy nor cauda equina syndrome was documented. Applicable guidelines would support another MRI in one of those situations; however, they are not evident within this record. In addition, the available diagnostics have been quite sufficient as valid adjunctive corroboration of the clinical physical examinations. Therefore, the requested service is not medically necessary.

ODG/Lumbar Spine/MRI: Indications for imaging -- Magnetic resonance imaging:

- 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.
- 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)