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**DATE OF REVIEW: 12/22/2010**

**IRO CASE #:**

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

Repeat MRI of the Lumbar Spine

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

This case was reviewed by a Texas licensed MD, specializing in Anesthesiology. The physician advisor has the following additional qualifications, if applicable:

ABMS Anesthesiology

**REVIEW OUTCOME:**

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

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Repeat MRI of the Lumbar Spine	72148	-	Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	IRO Request	TDI	18		
2	Diagnostic Test	Imaging Services Open MRI	2	11/04/2010	11/04/2010
3	Office Visit Report	Wellness	5	11/08/2010	12/06/2010

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male whose date of injury xx/xx/xx. Records indicate that the patient is status post surgery, but the date and extent of surgical intervention is not documented. Office notes from 11/10 report that the patient is requesting another MRI and EMG due to recurrent and progressively worsening low back pain. He states he has not felt any relief of pain from his surgery or pain management techniques he has been receiving. Records indicate that the patient has gone to Mexico for a second opinion where he had an MRI and EMG done, but no reports of these diagnostic studies were submitted for review. A pre-authorization request for repeat MRI of the lumbar spine was non-certified as medically necessary on 11/10/10. Reviewer

noted that additional documentation would be needed concerning the patient's progression of neurologic deficits, specifically relating to sensation, strength and range of motion. An addendum to this review noted that 47 pages of additional documentation were submitted for further review including EMG studies completed 02/06/09 and 10/23/10, therapy notes, and MRI studies completed 09/29/08, 11/06/08, 09/24/10 and 10/23/10, x-ray dated 07/23/09. It was determined that the additional documentation submitted had no bearing on the original determination and the request remained non-certified. An appeal / reconsideration request for repeat MRI of lumbar spine was noncertified on 12/01/10. The reviewer noted the claimant reported lack of pain relief from unspecified surgery and unspecified pain management techniques. There was no documentation of current objective physical / neurologic examination findings suggestive of red flags for serious spinal pathology and sustaining the suspected lumbar disc herniation and lumbar radiculopathy, with indication of neurologic progression as compared to baseline findings. The reviewer further noted the date of the last MRI along with imaging studies was not documented, and medical necessity was not established for repeat lumbar MRI.

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

Based on the clinical information provided, medical necessity is not established for repeat MRI of lumbar spine. The claimant is noted to have sustained injury to low back in xx/xx. He is status post undated and unspecified surgery. It appears the claimant has requested the repeat studies after undergoing second opinion in Mexico. No previous imaging studies were submitted for review. There is no current physical examination report with assessment of physical / neurologic examination report submitted with evaluation of motor, sensory and reflex changes. ODG Guidelines provide that repeat MRI is only indicated if there has been progression of neurologic deficit. Given the current clinical data, medical necessity is not established for repeat MRI of lumbar spine. IRO recommends upholding previous decisions.

ODG Low Back Chapter, online version MRIs (magnetic resonance imaging)

Recommended for indications below. MRI's are test of choice for patients with prior back surgery. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). ([Bigos, 1999](#)) ([Mullin, 2000](#)) ([ACR, 2000](#)) ([AAN, 1994](#)) ([Aetna, 2004](#)) ([Airaksinen, 2006](#)) ([Chou, 2007](#))

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.) ([Andersson, 2000](#))
- 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)

**TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS:** The Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with Rule 102.4(h), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on .