

MAXIMUS Federal Services, Inc.  
11000 Olson Drive, Suite 200  
Rancho Cordova, CA 95670  
Tel: [800] 470-4075 ♦ Fax: [916] 364-8134

---

**Notice of Independent Review Decision**

MAXIMUS Federal Services, Inc.  
  
11000 Olson Drive, Suite 200  
Rancho Cordova, CA 95670  
Tel: [800] 470-4075 ♦ Fax: [916] 364-8134

---

**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** December 28, 2010

**IRO CASE #:**

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

MRI of the lumbar spine.

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

M.D., Board Certified in Orthopedic Surgery.

**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 requested service, an MRI of the lumbar spine, is medically necessary for treatment of the patient's medical condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Request for a Review by an Independent Review Organization dated 12/6/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 12/7/10.
3. TDI Notice to IRO of Case Assignment dated 12/8/10.
4. Medical records from Pain Management, P.A. dated 11/8/10, 10/11/10, 9/7/10, 8/10/10, 7/13/10, 6/16/10, 5/5/10, 4/5/10, 3/8/10, 2/2/10 and 1/6/10.
5. Letters from PA-C dated 11/2/10 and 11/29/10.
6. Denial documentation.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

A female patient has requested authorization and coverage for an MRI of the lumbar spine. The Carrier has denied this request indicating that the requested service is not medically necessary for treatment of the patient's low back and right leg pain.

A review of the record indicates that the patient sustained an injury on xx/xx/xx after her foot went through some flooring in a portable building, twisting her right leg and knee. In October 2010, the patient had complaints of low back and mid-back pain. The patient describes her pain as stabbing and sharp with a severity of 8 ½ to 10 out of 10. A sensory examination was performed and revealed right L4 was decreased, right L5 was decreased and right S1 was decreased. Straight leg raise test was positive on the right and left. The patient's provider has recommended an MRI of the lumbar spine.

The Carrier indicates the requested service is not medically necessary. According to the Carrier, the patient did not exhibit signs or symptoms of progressive neurological deficit and has not had a recent traumatic incident to the lumbar spine.

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

I have determined that the requested MRI of the lumbar spine is medically necessary for this patient. The patient has leg and knee injuries which are known to aggravate pre-existing lumbar conditions. A disc herniation was noted on 12/4/08 on MRI. There is electromyography (EMG) evidence of S1 radiculopathy. In addition, sensory loss is present. Given these findings, there is a need to identify and verify the presence or absence of a significant neurological finding in the lumbar spine. This patient has a differential diagnosis of peripheral nerve injury from a fall versus aggravation of a spinal condition. An MRI is necessary to be able to differentiate between these two conditions. As such, I have determined that the requested lumbar spine MRI is medically necessary for this 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)