

Notice of Independent Review Decision

**IRO REVIEWER REPORT**

**DATE OF REVIEW:** 05/31/2011

**IRO CASE #:**

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

MRI of the lumbar with and without contrast 72158

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

The TMF physician reviewer is board certified in orthopedic surgery with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

**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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that the MRI of the lumbar with and without contrast 72158 is medically necessary to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Information for requesting a review by an IRO – 05/17/11
- Utilization Review Determination– 03/23/11, 03/29/11
- Review by Dr.– 03/29/11
- Utilization Review Worksheet– 03/18/11. 0324/11
- Procedure Orders by Dr.– no date
- Orthopedic Report by Dr.– 12/17/09 to 02/21/11
- Report of Manual Muscle Testing and Range of Motion – 01/13/11
- Report of EMG-NCV – 01/08/10
- Report of MRI of the lumbar spine – 09/25/09
- Operative Report by Dr.– 04/09/10,10/27/10
- One page of article from The Journal Of Bone & Joint Surgery, Volume 89-A, Supplement 3, 2007 The Current State of Cervical and Lumbar Spinal Disk Arthroplasty.
- One page of article from Diagnostic and Therapeutic Injections.

- Two pages of article Spine J, 2004 Sep-Oct;4(5):495-505, The effect of spinal steroid injections for degenerative disc disease.
- One page of article from Semin Roentgenol, 2004 Jan;39(1):7-23, Epidural steroid injections.
- Three pages from article from The Journal of Bone & Joint Surgery (American). 2006;88:1722-1725 Nerve Root Blocks in The Treatment of Lumbar Radicular Pain
- Two pages from article from Definitions of Clinical Findings Used in Individual in a DRE Category

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured worker sustained a work related injury on XX/XX/XX when he was lifting some heavy equipment and immediately felt pain in his lower back area. He has been treated with physical therapy, surgery, activity modification, epidural steroid injections and medication. The patient complains of constant pain in his back area, discomfort with side-to-side movement soreness and stiffness with pain radiating down his right lower extremity with numbness and tingling present. The treating physician is recommending that the patient undergo an MRI of the lumbar spine with and without contrast.

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

This patient has undergone surgical treatment laminotomy L5-S1 for herniated discs at L5-S1. He reports no significant benefit achieved from the surgery. He has persistent lumbar pain with straight leg raising positive on the right and negative on the left. The patient meets the criteria for an MRI scanning as published in the ODG, 2011, low back chapter. It would appear that there is a specific circumstance, "...uncomplicated low back pain, prior lumbar surgery..." that would be applicable. The medical necessity for this diagnostic study has been established.

**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)