

Clear Resolutions Inc.

An Independent Review Organization

6800 W. Gate Blvd., #132-323

Austin, TX 78745

Phone: (512) 879-6370

Fax: (512) 519-7316

Email: resolutions.manager@cri-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jun/04/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar MRI with/without contrast and a thoracic MRI without contrast

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

M.D. Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

5/2/11, 5/10/11

X-ray lumbar spine report 07/26/06

Medical Record review report 04/27/09

Dr. office notes 04/27/11

Dr. letter 05/02/11

Peer review reports 05/02/11, 05/10/11

ODG Low back – Lumbar & Thoracic

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female being evaluated for a request for Lumbar MRI with/without contrast and a thoracic MRI without contrast. The claimant's record contains a conventional x-ray of the lumbar spine with an impression of status post L4 to S1 anterior fusion and an L4-5 laminectomy. The claimant has an evaluation of 04/27/11 indicating that she is being evaluated for a SynchroMed pump refill and re-program. The claimant is able to complete activities of daily living without any assistance. She does report pain and the use of pain medication. The claimant is being evaluated for lumbar spinal stenosis. She reports numbness in the lateral thighs, left more than the right, and in the lateral lower legs, left more than right, and the feet, left more than right. The claimant's medical history is significant for prior herniated disc, back surgery, obesity, and poor back conditioning. She has had two epidural steroid injection series and a spinal cord stimulator trial that did not provide adequate pain relief. The claimant had a brief physical examination which did not include any detail with respect to a lower extremity neurological examination other than stating that there is positive bilateral straight leg raise for back pain and radiculopathy and a positive bilateral slump for back pain and radiculopathy. The claimant had the rate of her intrathecal pump today by 5 percent, and also a request is noted for a lumbar and thoracic MRI with and without contrast to evaluate the spine and the intrathecal pump catheter placement. There is

a follow-up request document by the treating physician on 05/02/11 indicating she has an implanted intrathecal narcotic pump for low back and leg pain secondary to failed back surgery. The claimant had reported a recent increase in pain and bilateral leg pain. It is assessed that the claimant's new onset of increased pain warrants new imaging of the postoperative lumbar spine, and a thoracic spine MRI is also needed to visualize the tip of the pump catheter to rule out granuloma formation, which could explain her increased pain.

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

Official Disability Guidelines low back outline indications for magnetic resonance imaging (MRI) of the thoracic and lumbar spine. The criteria primarily concern the objective demonstration of neurological deficit in the lower extremity either with respect to lumbar radiculopathy or objective evidence of myelopathy, neither of which have been documented for this claimant.

Notwithstanding the explanation of the granulation at the tip of the intrathecal pump, with this claimant having demonstrated no evidence of objective neurological deficit either with respect to lumbosacral radiculopathy or myelopathy, the request for Lumbar MRI with/without contrast and a thoracic MRI without contrast is not found to be medically necessary.

Official Disability Guidelines, Treatment in Worker's Comp 16th edition, 2011 Updates, Low back

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.
- 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-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

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)