

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jun/21/2011

**IRO CASE #:**

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

MRI of the lumbar spine without contrast

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

M.D., Board Certified 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Official Disability Guidelines-Treatment for Workers' Compensation, Chapter: Low Back – Lumbar and Thoracic, MRIs

Utilization review determination 04/29/11

Utilization review determination 04/19/11

Peer review M.D 07/28/08

Medical record / peer review M.D. 07/07/10

Ultrasound of mass in left back 01/25/07

Chart note M.D. 03/03/05

Follow-up evaluation M.D. 12/13/04

Clinic note 04/11/11 and 03/07/11

**PATIENT CLINICAL HISTORY SUMMARY**

The injured employee is a XX year-old male whose date of injury is XX/XX/XX. Records indicate he was injured when he slipped and fell on a wet floor. Records indicate the injured employee underwent MRI of lumbar spine and sacrum on 06/02/XX, which reported disc desiccation at L5-S1 with mild loss of disc height and mild posterior bulge at that level with no neural impingement. Electrodiagnostic testing on 07/21/04 was reported as normal. Epidural steroid injections provided no benefit. Lumbar discogram was reported to show concordant pain at L5-S1. The patient underwent lumbar discectomy and fusion at L5-S1 on 05/31/05. The patient initially did better but had increasing symptoms and subsequently underwent placement of spinal cord stimulator. This was noted to have helped somewhat with back pain but did not help his main complaint of right radicular pain. Medical report dated 04/11/11 indicated the injured employee complains of lumbar pain rated 6/10 on pain scale. Physical examination of lumbar spine revealed paraspinal muscle tenderness. Straight leg raise was positive bilaterally at 90 degrees. A request for MRI of lumbar spine without contrast was reviewed on 04/20/11 and determined as non-certified as medically necessary. The reviewer noted there was no objective documentation that the injured employee had undergone and failed a course of physical therapy as part of preliminary conservative measures as there were no therapy reports included. It was further noted that maximized pharmacotherapy was not validated with pain and symptom logs with mediation modality. Official reports of prior imaging studies were not submitted for review, and there was no indication of significant change in symptoms or exam findings to support the request. The reviewer had peer to peer

discussion with the requesting provider who stated the injured employee has back pain with new findings of right leg radiculopathy and needs new MRI. No recent physical therapy or x-rays for new findings. It was noted upon review of records report from 06/07/10 indicated the injured employee had right leg radicular pain, and EMG/NCV 01/23/06 found right L5 radiculopathy. Current findings do not appear to be new and can be explained by prior testing and found in prior reports.

An appeal request for MRI of lumbar spine without contrast was reviewed on 04/27/11 and determined as non-certified as medically necessary. It was noted the injured employee complains of pain, numbness and weakness of right lower extremity. Physical examination of lumbar spine revealed paraspinal muscle tenderness. Straight leg raise test was positive bilaterally at 90 degrees. Current guideline recommendations did not support repeat MRI studies without significant change in symptoms or examination findings suggestive of significant pathology. The injured employee was noted to have had previous MRI and x-ray studies done, but no official reports were submitted for review. Additionally, there was no indication from the documentation submitted that the injured employee has had significant change in symptoms or worsening of symptoms suggestive of significant pathology.

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

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld. This injured employee is noted to have sustained an injury to his low back secondary to slip and fall on XX/XX/XX. After failing a course of conservative treatment, the patient underwent L5-S1 discectomy and fusion on 05/31/05. He reportedly did better following surgery but subsequently experienced increasing symptoms over time. Repeat electrodiagnostic testing performed 01/23/06 reported right L5 radiculopathy. The injured employee subsequently underwent placement of spinal cord stimulator, which was noted to have helped with back pain but not right radicular pain. The records reflect that the injured employee had undergone previous imaging studies including MRI and plain radiographs of lumbar spine; however, no official radiology reports were included in the records submitted for review. There also was no comprehensive history of conservative treatment completed following surgical intervention. On examination there was no evidence of significant change in symptoms or progression of neurologic deficit to support the need for repeat MRI of lumbar spine. Based on this information, the reviewer finds there is no medical necessity at this time for MRI of the lumbar spine without contrast.

#### **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)