

Notice of Independent Review Decision

DATE OF REVIEW: 03/02/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat MRI Lumbar Spine (72148) Medically necessary.

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

The physician performing this review is Board Certified, American Board of Orthopedic Surgery. He has been in practice since 1982 and is licensed in Texas, Oklahoma, Tennessee and California.

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.

Uphold previous denial. ODG guidelines indicate for repeat MRIs of the lumbar spine, a worsening focal neurological deficit be documented. At this time, there is no worsening focal neurological deficit documented in the medical records provided for review.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records Received: 15 page fax 2/10/11 Texas Department of Insurance IRO request, 72 page fax 2/11/11 Provider response to disputed services including

administrative and medical records. Received 5 faxes 7, 124, 123, 123, 402 pages dated 2/15/11 URA response to disputed services including administrative and medical records

PATIENT CLINICAL HISTORY [SUMMARY]:

This male was injured xx/xx/xx. The patient was carrying heavy objects at work and incurred back pain.

The patient was initially seen xx/xx/xx, physician's assistant, who prescribed Flexeril and physical therapy.

The patient then was treated ongoing with medications and a heating pad and physical therapy.

Subsequently, when the patient did not respond, an MRI of the lumbar spine was performed 02/04/09 noting increased epidural fat and synovitis in L3-4 and L4-5 facet joints.

The patient, when seen 05/12/09 by Dr., was prescribed physical therapy, antiinflammatory medication, muscle relaxants, massage, and heat therapy.

The patient did see D.C., for chiropractic evaluation. The patient, when seeing Dr. 08/05/09, was felt to have MRI evidence of the L5-S1 disk to be about 4-5 mm protrusion. That appeared to be compressing on the thecal sac centrally. Some disk dehydration was felt to be present also. Physical therapy, 6 sessions, was approved, and the patient did have chiropractic 12 sessions, 08/07/09 through 09/09/09.

An FCE 12/04/09 noted a medium physical demand level.

Repeat MRI 12/04/09 noted disk desiccation at L5-S1 with modic Type 2 signal and abnormality. At the anterior superior endplate at L4, the patient did not have extrinsic compression of an exiting nerve sleeve. At L3-4 and at L4-5, mild to moderate hypertrophic changes of the articular facets with a 2- to 3-mm disk bulge could possibly cause extrinsic compression of the L5 sleeve bilaterally. At L5-S1, findings were noted that could cause extrinsic compression of the S1 nerve.

An electrodiagnostic study 12/07/09 noted no evidence of neuropathy or lumbar radiculopathy.

The patient saw Dr. 01/04/10, and the options given to the patient were to live with the pain, continue physical therapy, or undergo epidural steroid injections.

The DYLL REVIEW

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The patient did have a peer review 04/26/10 by Dr., who opined the medical records reflected a strain of the low back with ongoing, appropriate treatment. However, the epidural steroid injections were not felt to be medically indicated in line with *ODG* criteria.

Dr. in the designated doctor evaluation 05/14/10 recommended epidural steroid injections, facet injections, and NSAIDs.

The patient did continue to see Dr. for chiropractic evaluation and treatment.

The patient on 06/18/10 was seen by Dr. and again recommended to receive epidural steroid injections.

On 07/21/10, Dr. in a peer review noted the designated doctor evaluation findings and indicated that evaluation did not show any evidence of a radiculopathy. Dr. disagreed with the designated doctor's recommendation of epidurals, as they did not follow *ODG* criteria in that there was not a radiculopathy documented by objective findings.

The patient did have a recommendation for noncertification of the repeat MRI by Dr. noting there were no documented neurological deficits and lack of recent examination since January 2010 noting neurological deficits, and the MRI from 02/04/09 and repeat MRI would not support an absence of repeat trauma or specific change, repeat MRI.

Dr. noted on 01/07/11 that the patient had undergone physical therapy. Physical examination revealed normal motor, sensation, and reflexes in both upper and lower extremities. There was paravertebral spasm in the lumbar spine. There was minimal restriction of flexion/extension, moderate restriction in rotation of the lumbar spine. The diagnosis was lumbar strain/sprain, and epidural injections again were recommended.

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

The rationale for recommending noncertification of the repeat MRI is that *ODG* indicates in the "Low Back" chapter under "MRI" that repeat MRIs of the lumbar spine should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology, a tumor, infection, fracture, neural compression, recurrent disk herniation. At this time, such information is not noted in the medical record, as the patient's clinical scenario has not changed in the medical records reviewed and there is not a new injury having occurred that would warrant a repeat MRI.

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)