

**AccuReview**  
An Independent Review Organization  
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Notice of Independent Review Decision

**DATE OF REVIEW:** MARCH 10, 2011

**IRO CASE #:**

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

Magnetic Resonance (EG, Proton) Imaging, Spinal Canal And Contents, Lumbar;  
Without Contrast Material

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

This physician is Board Certified Physical Medicine and Rehabilitation Physician  
with 15 years of experience.

**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.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

On February 25, 2008, an MRI of the lumbar spine was performed. Impression:  
1. Degenerative disc disease is seen involving L4-L5 disc space. 2. Central and

left side disc protrusion at the L5-S1 level with obliteration of epidural fat and impingement on the left S1 nerve root in the lateral recess and neural foramen. 3. Remainder of the lumbar intervertebral disks appears normal. 4. No evidence of central spinal canal stenosis. 5. Lateral recess, foramen stenosis on the left side at the L5-S1 level. 6. No evidence of spondylolysis or spondylolisthesis as interpreted by an M.D.

On March 5, 2008, the claimant was evaluated by an M.D. He describes his back [pain as tingling, hot, cold, constant, annoying and severe. Impression: 1. Disk disruption L5-S1 resulting in back pain and left lumbar radicular syndrome. He was placed on Norco 5/325 #90 and Celebrex 200mg # 30. Injections were also recommended.

On March 19, 2008, the claimant was re-evaluated by an M.D. His knee jerks on the right are 2/4+ and absent on the left. Skin is warm and dry.

On April 2, 2008, the claimant was re-evaluated by an M.D. On March 27, 2008, a transforaminal left L5-S1 lumbar ESI was performed. He reports he is basically pain free. He still has intermittent burning on the lateral aspect of the left calf.

On April 23, 2008, the claimant was re-evaluated by an M.D. His ESI has since worn off. The paraesthesias down the lateral aspect of his lower extremity is gone, however is still has significant back pain.

On March 14, 2008, the claimant was evaluated by an M.D. His complaints include constant low back pain, intermittent left lower extremity symptoms and numbness and tingling in the lateral 2 toes of the left foot that comes and goes. DTRs are equal and reactive. Strength is 5/5 of the hip flexors, EHL and dorsi/everters. A caudal ESI was recommended for diagnostics.

On June 19, 2008, an M.D. performed a peer review. He determined that treatment and diagnostic testing are necessary, he is not receiving maintenance care and treatment is related to the accident/injury.

On July 2, 2008, the claimant was re-evaluated by an M.D. A caudal ESI was performed on June 19, 2008 which essentially resolved his pain. He thinks he is 90% improved. He is also using Lidoderm patches which help greatly.

On August 13, 2008, the claimant was re-evaluated by an M.D. The effects of the injection have now worn off and he is symptomatic again. He has failed all conservative treatments including physical therapy, medications and injections.

On September 24, 2008, the claimant was re-evaluated by an M.D. Lateral bending exhibits paraspinal spasms on the left. His DTR's are absent at the knees, intact at the ankles. A repeat Caudal ESI was recommended.

On October 20, 2008, the claimant was evaluated by an M.D. His pain is 7 out of 10 and it interferes with his daily living. His current medications include Norco, Zanaflex, Celebrex, Lunesta, Lyrica and Lidoderm. He has a mild left antalgic limp. Physical therapy was recommended.

On March 4, 2009, a Dr. performed an ESI at left L5-S1.

On March 25, 2009, the claimant was re-evaluated by an M.D. His knee jerks are absent on the left and ¼+ on the right.

On July 8, 2009, the claimant was evaluated by an M.D. He has continuous low back pain. He has had 5 injections performed which helped somewhat. He is able to heel and toe walk without difficulty. He has a normal gait pattern. A Dr. recommended an updated MRI of the lumbar spine.

On July 29, 2009, an MRI of the lumbar spine was performed. Impression: 1. Small right foraminal and far lateral disc protrusion at L4-5 which moderately narrows the right neural foramina and contacts the right L4 nerve root. 2. Additional mild degenerative changes at L2-3 and L5-S1 as above. No definite etiology for left leg numbness as interpreted by an M.D.

On November 24, 2009, the claimant was re-evaluated by an M.D. He has been wetting the bed once a week for the past month and a half.

On December 4, 2009, the claimant was re-evaluated by an M.D. An MRI performed on December 2, 2009 shows no evidence to explain his urinary incontinence. The Dr. is suggesting urologic evaluation.

On May 19, 2010, the claimant was re-evaluated by an M.D. On March 2009 and November 2009 the claimant underwent an ESI of the lumbar spine.

On October 14, 2010, the claimant was re-evaluated by an M.D. He received a 75% pain reduction following his ESI at L5-S1 on October 7, 2010. He may be a candidate for 1 or 2 level disc replacement.

On October 14, 2010, an M.D. placed the claimant at full duty work status.

On November 30, 2010, the claimant was evaluated by an M.D. He is seen for surgical consultation. Seated straight leg raising on the right is negative at 90 degrees but seated straight leg raising on the left is positive at 85 degrees with a mildly positive Lasegue's. Reflexes absent bilaterally at the knees but symmetric at both ankles. The Dr. recommended an updated MRI scan of the lumbar spine.

On December 21, 2010 a D.O., a preventative medicine physician performed a utilization review on the claimant. Rationale for denial: Based on the documentation submitted for review, there are no red flags and/or significant

positive objective orthopedic/neurologic findings specifically radicular complaints and/or signs to support request for an MRI scan of the low back. Therefore it is not certified.

On January 4, 2011 an M.D., an anesthesiology physician, performed a utilization review on the claimant. Rationale for denial: There is no evidence of progression of neurological deficit on clinical examination. A repeat MRI is only indicated if there is a progression of neurological deficit. Therefore it is not certified.

**PATIENT CLINICAL HISTORY:**

On xx/xx/xxxx this male began feeling back pain.

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

Decision to deny repeat MRI of Lumbar Spine is upheld. Based on the ODG Low Back Chapter, “repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of a significant pathology (i.e. tumor, infection, fracture, neuro compression, recurrent disc herniation.)” Submitted clinical records do not support a significant change in symptoms or findings to necessitate repeat imaging.

**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)