SENT VIA EMAIL OR FAX ON
May/03/2011

True Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
May/03/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
repeat MRI without contrast to thoracic spine

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Orthopedic Surgeon, Practicing Neurosurgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY
The injured employee is a male who was injured on xx/xx/xx amputating his left arm below the elbow. CT scan of the thoracic spine performed on 09/22/08 reported findings of nondisplaced fractures of the right 8th, 9th, and 10th transverse processes and the right 8th, 9th, and 10 ribs posteriorly; no compression fracture or subluxation. Disc spaces appear maintained. There were no other acute fractures, dislocations or subluxations or other osseous pathologies. Bibasilar atelectatic changes are present. Surrounding osseous and soft tissue structures appear otherwise unremarkable. Thoracic spine MRI performed on 11/25/08 revealed disc dehydration and desiccation from T2 through T10; old Schmorl's nodule along the inferior vertebral end-plate of T9. The injured employee was seen for consultation and evaluation of lower back pain on 10/28/10. He presented with back pain/lumbar radiculopathy, with pain located in the thoracic spine and lumbar-sacral spine. The injured employee was seen on 01/24/11 for follow-up of low back pain and leg pain. He reported that ESIs and facet injections have provided little to no relief.

A request for repeat MRI without contrast to thoracic spine was determined as not medically necessary per review dated 03/31/11. It was noted that the documentation submitted for review did not indicate there were significant objective or subjective findings upon examination to warrant repeat MRI. There was a lack of documented imaging evidence or significant findings upon physical examination, and the request for repeat MRI without contrast to thoracic spine was not medically necessary.

A reconsideration/appeal request for repeat MRI without contrast to thoracic spine was determined as not medically necessary per review dated 04/06/11. It was noted that the documentation submitted for review was insufficient to note objective clinical findings for progressive neurological deficit or myelopathic findings. Also there was a lack of documentation of objective clinical findings of radicular symptoms. As such the request for repeat MRI without contrast to thoracic spine was determined as not medically necessary at this time.

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

Based on the clinical data provided, the request for repeat MRI without contrast to thoracic spine is not seen as medically necessary. The injured employee sustained an injury on xx/xx/xx with traumatic amputation below the elbow on the left. He also was struck by a large metal bell in the back. He developed low back pain radiating to the bilateral lower extremities. CT scan of the thoracic spine showed nondisplaced fractures of the right 8th, 9th, and 10th transverse processes and the right 8th, 9th, and 10 ribs posteriorly. Thoracic spine MRI revealed disc dehydration and desiccation from T2 through T10; old Schmorl's nodule along the inferior vertebral end-plate of T9. The injured employee reported that epidural steroid injections and facet blocks provided little to no relief. Per ODG guidelines, repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. On examination there was no evidence of progressive neurologic deficit or significant change in symptoms. Accordingly, medical necessity is not established for repeat MRI of the thoracic spine.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES