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**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** April 27, 2011

**IRO CASE #:**

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

Repeat MRI lumbar without contrast.

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

M.D., Board Certified in Orthopedic Surgery.

**REVIEW OUTCOME**

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

- |   |                                  |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld    | (Agree)                          |
| <input type="checkbox"/> Overturned           | (Disagree)                       |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

The requested service, repeat MRI lumbar without contrast, is not medically necessary for treatment of the patient's medical condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Request for a Review by an Independent Review Organization dated 4/5/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 4/6/11.
3. Notice of Assignment of Independent Review Organization dated 4/7/11.

4. Medical records from MD dated 10/30/09, 11/6/09, 11/20/09, 2/8/10, 4/7/10, 5/7/10, 5/21/10, 6/23/10, 1/3/11 and 1/27/11.
5. MRI of the lumbar spine dated 10/6/09.
6. Electromyography/Nerve Conduction Studies dated 1/20/11.
7. Follow-up evaluations from Medical Center dated 1/27/11, 3/1/11 and 3/21/11.
8. Reports from DO dated 1/22/10 and 8/10/10.
9. Workers' Compensation Work Status Report dated 1/27/11, 3/1/11 and 3/21/11.
10. Denial documentation.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who sustained a work-related back injury on xx/xx/xx when she tried to break up a physical altercation where she worked and was thrown against the wall. The patient has a past history of lumbar fusion at L4-5 and L5-1 which was performed 25 years ago. After the injury in xx/xx, she developed pain into her back and then predominately into her left leg in an L5 distribution. An MRI of the lumbar spine performed on 10/6/09 showed mild neural foraminal encroachment bilaterally at L3-4 and to a lesser degree at L2-3 due to a small amount of lateralizing disc material and moderate facet hypertrophic changes with the exiting dorsal root ganglion surrounded by fat and spinal canal well in excess of a centimeter at both segments and post-operative changes at L4-5 and L5-S1 with widely decompressed spinal canal and neural foramina with minimal encroachment. The patient underwent epidural steroid injection on 1/7/10 without improvement and EMG/NCV study performed on 1/20/11 was normal. The patient's provider has recommended a repeat MRI of the lumbar spine without contrast.

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

Review of the submitted documentation indicates the patient had a lumbar spine MRI in October 2009 that showed minimal neural foraminal encroachment bilaterally at L3-4 and less so at L2-3; post-operative changes at L4, L5 and S1; and widely decompressed spinal canal with minimal encroachment. A repeat lumbar MRI has now been requested. According to the Official Disability Guidelines (ODG), "repeat MRI is not routinely recommended and should be reserved for significant change in symptoms and/or findings suggestive of significant pathology." In the case of this patient, there is no evidence in the submitted records of infection, radiculopathy or any significant neurological problem. The patient has undergone a thorough workup without identification of any obvious surgical pathology. Nor is there documentation of objective or significant subjective findings of a progressive problem. As such, the patient does not meet ODG criteria for a repeat lumbar MRI. Therefore, I have determined the requested service is not medically necessary for treatment of the patient's medical condition.

**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)