



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 9/26/2011

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of a lumbar MRI with and without contrast (72158).

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

**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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a lumbar MRI with and without contrast (72158).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
Health Care WC, MD, and Injured Employee

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Health Care WC: Denial Letters – 7/19/11 & 8/8/11; Group of Texas Pre-auth Requests – 2/7/11, 2/16/11, 7/14/11, & 8/19/11, Patient Information Form – 2/1/11, Appeal Request – 8/1/11, Workers' Compensation Intake – undated, History and Physical – 2/1/11; MD Office Notes – 7/12/11-8/15/11, Letter – 2/15/11; and Hospital MRI Lumbar Spine w/wo contrast – 2/13/11.

Records reviewed from MD: Hospital Operative Report – 4/18/11, Surgical Pathology reports – 11/3/00 & 4/18/11, Operative Report – 11/3/00, Lumbar

Spine X-ray – 4/18/11, Lumbar Spine x-ray report – 11/3/00, ECG report – 4/12/11, Outpatient Lab Results – 4/12/11 & 10/26/00, History and Physical – 4/12/11, History and Physical report – 4/18/11; Group of Texas Operative Charge Report – undated, Operative report – 11/6/00; MRI Lumbar Spine – 3/1/01, Lumbar Spine views – 2/15/01; MD Office Note – 3/29/11-6/13/11; Group of Texas letter – 5/17/11, Operative Note – 4/19/11, Letters – 3/21/00-3/27/01, & 2/1/11-2/15/11, Patient History Form – 2/1/11; Chart Note – 9/1/00-1/15/02, and Patient History Questionnaire – 3/21/00.

Records reviewed from the Injured Employee: Personal Email – 9/13/11.

A copy of the ODG was not provided by the Carrier or URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant was injured on xx/xx/xx. On 2/13/11, an MRI revealed nerve root impingements at L4 and L5, along with evidence of prior surgical intervention and multi-level stenosis. On 4/18/11, the claimant's diagnosis was recurrent L4-5 disc herniation with stenosis and scar tissue. Decompression and removal of disc and scar tissue was performed by a Dr. That Attending Physician's records were reviewed in detail. Previously, as of 11/3/2000, the claimant underwent a decompression at L5-S1 for recurrent disc herniation and stenosis (s/p prior laminectomy on 4/10/2000). On 7/12/11, back pain and residual numbness was noted, although the pre-operation leg pain and foot drop had resolved and motor power was "full." On 8/15/11, the Attending Physician described the claimant's ongoing low back and burning dyesthesias in the feet. Records have reflected that the claimant has had an ongoing large body habitus. An additional note/letter dated or provided on 9/13/11 (from the claimant) has been provided for review. This was reviewed in detail. He essentially clarifies and/or rebuts the medical record of his own provider with regards to the claimant's ongoing complaints / condition. Denial letters noted the significant post-operative improvement overall, and, the lack of significant worsening or severe objective findings as a lack of med. necessity for a repeat MRI.

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

The claimant has done relatively well post the most recent surgical procedure. With a resolution of the pre-operative leg pain and foot drop, along with ongoing objective findings of "full" motor strength in the lower extremities; a repeat (post-op) is not reasonable or necessary. Residual back pain and some degree of burning dyesthesias is not unexpected after multiple spinal operative procedures. This is on the basis of prior surgical interventions and residual scarring. With a lack of severity of objective findings and a lack of progressive neurological deficit, there is no guideline-associated indication for another lumbar MRI; therefore, the requested service is not medically necessary.

**Reference: ODG Lumbar Spine Imaging**

“MRIs (magnetic resonance imaging) Recommended for indications below. MRI's are test of choice for patients with prior back surgery. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation).

**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)