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**Notice of Independent Review Decision**

**IRO REVIEWER REPORT – WC (Non-Network)**

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**DATE OF REVIEW:** 10/10/11

**IRO CASE #:**

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

Lumbar MRI without contrast

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

Board Certified in Orthopedic Surgery

**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.

Lumbar MRI without contrast - Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

DWC-73 forms dated 01/19/11, 01/26/11, 02/10/11, 02/17/11, 03/11, 03/17/11, 04/25/11, 05/25/11, 06/23/11, 07/22/11, and 09/15/11 from D.O.

Physical therapy notes dated 02/17/11, 02/23/11, 03/02/11, 03/04/11, and 03/07/11

An MRI of the cervical spine dated 02/17/11 and interpreted by M.D.

Notices of Disputed Issues (DWC-11 Form) from EMC dated 02/23/11, 06/10/11, and 08/02/11

Evaluations with Dr. on 02/25/11, 03/09/11, 04/15/11, 04/25/11, 05/25/11, 07/22/11, and 09/15/11

A patient registration form dated 03/17/11

A facsimile from Medical Clinic dated 03/17/11 for an EMG/NCV study of the right shoulder

A preauthorization form fated 03/31/11 from M.D. for an EMG/NCV study of the right upper extremity

A peer review dated 04/13/11 from M.D. from MES solutions

A preauthorization request for an MRI of the lumbar spine dated 04/15/11 from Diagnostic Center

An E-mail Notification for an Urgent MRI of the lumbar spine dated 04/18/11

A Notification of Determination from M.D. for an urgent MRI of the lumbar spine

A letter addressed To Whom It May Concern on 04/29/11

Another Notification of Determination from M.D. dated 05/05/11 for an urgent MRI of the lumbar spine

Evaluations with M.D. at Institute dated 06/02/11,

A Script for Orders dated 06/02/11 from Institute from Dr.

X-rays of the lumbar spine dated 06/02/11 and interpreted by Dr.

A fax from Institute requesting a lumbar MRI without contrast dated 07/22/11 and 08/15/11

A Notification of Determination from M.D. dated 07/27/11

An Independent Medical Evaluation (IME) with M.D. dated 08/18/11

Another Notification of Determination from M.D. dated 08/26/11

## **PATIENT CLINICAL HISTORY**

On 02/17/11, Dr. noted the patient got numbness and tingling and his current medications were Flexeril and Vicodin. The assessments were shoulder joint pain and brachial neuritis. On 02/21/11, Mr. prescribed therapy three times a week for four weeks. An MRI of the cervical spine dated 02/17/11 revealed straightening of the normal lordosis and diffuse spondylosis was identified. At C3-C4, there was a right foraminal protrusion osteophyte seen at C3-C4 resulting in mild right foraminal stenosis. There were bilateral foraminal protrusion osteophytes seen at C5-C6 with also a central protrusion seen. There was mild relative canal stenosis identified and left worse than right foraminal stenosis. There was right worse than left foraminal stenosis seen at C6-C7 with mild relative canal stenosis due to foraminal stenosis and protrusion. There was right foraminal stenosis seen at C7-T1. On 02/23/11 and 03/09/11, the patient attended therapy with Mr. A PLN-11 from the carrier dated 02/23/11 stated they disputed and contested that the injury of 01/19/11 extended to or included any other injury other than a strain of the right shoulder and a strain of the lumbar spine. On 03/17/11, Dr. noted normal range of motion in the lumbar spine, but noted there was decreased sensation to pinprick in the right third through fifth

fingers. Dr. ordered an EMG/NCV study and an MRI of the lumbar spine on 04/15/11. Dr. Irvine wrote a letter To Whom It May Concern dated 04/29/11 disagreeing with Dr. peer review. Dr. recommended an MRI of the lumbar spine on 06/02/11. X-rays that day showed mild spondylosis with retrolisthesis of L4 on L5 and anterolisthesis of L5 on S1, which was mild and less than 3 mm. Dr. again recommended an MRI of the lumbar spine 07/22/11. Dr. provided a Notification of Determination dated 07/27/11 non-authorizing the recommended MRI of the lumbar spine without contrast. Dr. performed an Independent Medical Evaluation (IME) on 08/18/11. Dr. noted he did not find overt evidence of radiculitis and felt the patient was not a surgical candidate. Dr. also provided a Notification of Determination dated 08/26/11, non-certifying the requested lumbar MRI without contrast. On 09/15/11, the patient stated in the last month or so he had noticed a sharp pain along with some numbness and tingling going down both legs, but more severe in his left leg. Dr. again ordered a lumbar MRI.

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

The patient's has been examined by multiple physicians and no objective or supportable neurological abnormalities have been determined or found in the lower extremities. The patient's pain complaints are in his lower back. Plain film x-rays were diagnostic. The Official Disability Guidelines (ODG) gives very specific criteria for obtaining an MRI. Uncomplicated lower back pain when there is suspicion of cancer, infection, or other red flags would be an indication for an MRI, but those criteria are not met here. There is no radiculopathy, so the next criterion is not met. The patient has not had prior lumbar surgery and he does not have cauda equina syndrome, so those criteria have not been met. There is no evidence of trauma or a fracture, so those criteria are not met. The patient does not have myelopathy and therefore that criterion is not met. Given the normal neurological examination, the presence of diagnostic plain film x-ray, and the absence of the indications required by the ODG, the MRI of the lumbar spine without contrast is neither reasonable nor necessary and the previous adverse determinations should be upheld at this time.

**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 AND KNOWLEDGE BASE
- 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)