



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 2/14/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a repeat lumbar MRI.

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.

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 repeat lumbar MRI.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: Report of Medical Examination – 12/29/11; Medical Center Radiology report – 2/19/11, Right Shoulder MRI Report – 3/25/11, Lumbar Spine MRI Report – 3/25/11; MD Office Notes – 2/23/11-11/30/11; Office Consultation Report – 8/22/11; Sports Medicine and Rehabilitation Ongoing Plan of Care – 6/15/11; Orthopedic Group New Patient Initial Evaluation – 5/17/11; MD Initial Office Visit – 4/19/11 & 9/2/11; SpineCare Consultants Office Notes – 9/20/11 & 11/13/11; and Doctor, Pain & Diagnostics & Therapeutics Operative Note – 8/8/11.

Records reviewed from: Report of Medical Examination – 2/23/11-1/26/12, Nurses Notes – 6/21/11; Medical Center of CT Spine Thoracic w/o Contrast Report – 2/19/11, Thoracic Spine Radiology report - 2/19/11, Right

Shoulder Radiology Report – 2/19/11, C-Spine report – 3/28/11; Orthopedic Group PT Order – 4/19/11(x3); Sports Medicine and Rehabilitation Ongoing Plan of Care – 5/27/11; MD Letter to Dr. – undated; MD Office Notes – 12/29/11 & 1/26/12; Pre-auth Approval Letter – 1/4/12, and Pre-auth Denial Letter – 1/4/12.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The Attending Physician records were reviewed, including from 12/29/11. The patient was noted to be post right shoulder and a low back injury due to a fall. He underwent shoulder surgery and extensive post-operative therapy. There was a diagnosis of a (post-operative) painful and stiff “frozen shoulder.” (A pre-operative (3/25/11 dated) shoulder MRI reflected a partially torn rotator cuff and AC joint arthropathy). The Attending Physician’s considerations were for a repeat shoulder MRI (and possible additional shoulder surgery with lysis of adhesions).

There was also a notable history of concurrent prior and ongoing treatment for lower extremity radiculopathy. The Attending Physician also requested a repeat lumbar spine MRI, for diagnoses of discopathy with radiculopathy. On 12/29/11, ongoing low back and right leg pain was noted, despite therapy and one ESI. Exam findings included an antalgic gait and decreased lumbar motion. On the prior 2/23/11 and 6/21/11, low back pain was noted, along with normal motor power and 1+/1+ lower extremity reflexes. On 2/23/11, lumbar osteophytes were noted on x-ray. A 3/25/11 dated lumbar MRI revealed an L4-L5 disc extrusion/protrusion”. On 3/28/11, the Attending Physician denoted a “disc protrusion” at L4-5 on the MRI of the lumbar spine. Some Attending Physician notes reflected issue related to ‘non-show’/compliance issues. On 4/19/11, Dr. noted that the L4-5 disc protrusion had “some contact with traversing L5 root.” On 11/13/11, Dr. noted that the patient’s symptoms are “unchanged” since the onset. Denial letter(s) noted the lack of significant change in subjective and objective findings since the last MRI, along with the prior MRI not showing significant neurocompression and some issues regarding suboptimal compliance with office visits.

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

The patient has not been documented to have had a significant alteration of subjective or objective neurologic findings in the lower extremities. In addition, the findings have not been documented to be severe and the patient is not post-operative for the lumbar spine. Therefore as per applicable ODG criteria, an additional/repeat lumbar MRI is not medically necessary at this time.

ODG Lumbar Spine:

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).There is support for MRI, depending on symptoms and signs, to rule out serious pathology such as tumor, infection, fracture, and cauda equina syndrome. Patients with severe or progressive neurologic deficits from lumbar disc herniation, or subjects with lumbar radiculopathy who do not respond to initial appropriate conservative care, are also candidates for lumbar MRI to evaluate potential for spinal interventions including injections or surgery. For unequivocal evidence of radiculopathy, see AMA Guides

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)**