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Notice of Independent Review Decision

DATE OF REVIEW: 2-13-2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a MRI lumbar spine without and with dye.

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 Anesthesiology.

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 disagrees with the previous adverse determination regarding the MRI lumbar spine without and with dye.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: and Neurosurgical Associates.

These records consisted of the following:

MDR paperwork including denials 1-6-2012 and 1-17-2012 (1-16-2012)
Neurosurgical Associates Treatment/Preauthorization Request and Reconsideration Forms
MD reports 12-28-2011, 9-28-2011, 8-16-2011, 6-15-2011, 6-28-2011, 4-20-2011,

Procedure report 6-28-2011

Radiology reports 4-15-2011, 6-28-2011, 6-24-2011, and 4-13-2011

DWC Forms

Health Center reports 12-14-2011, 12-8-2011, 10-13-2011, 11-3-2011, 9-27-2011, and 4-13-2011

Post-operative report 7-12-2011

Medicine Clinic 5-10-2011

Witness Comments

Accident Report xx/xx/xx

Hillcrest Baptist Medical Center report 4-25-2011

Telephone Encounter 4-18-2011

Controlled Substance agreement 4-20-2011

Brief Pain Inventory 6-9-2011

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who is status post left L5-S1 lumbar hemi laminectomies for decompression and discectomy in April 2010. The patient subsequently suffered a fall in February xxxx and developed increasing pain in his lower back and left leg. On 04/20/2011, the patient describes lower back pain greater than lower leg pain that extends down to the level of his foot. Also, numbness and paraesthesias were reported in the left lower extremity. Lumbar MRI dated 04/15/2011 showed prominent soft tissue in the left lateral recess and proximal left neuroforamen at L5-S1 that extends down to the lateral recess of S1 or S2. At L4-L5, there is bilateral facet degeneration, with mild diffuse bulging and mild narrowing of the central canal. At L3-L4 there is degeneration and ligamentous hypertrophy. MRI demonstrates radiculopathy. Patient was scheduled for and had left sided L5-S1 hemi laminectomies for decompression and discectomy 06/28/2011. Patient had several follow-ups with continued lower back pain. Patient was recommended for repeat lumbar MRI for further evaluation.

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

Based on the records submitted for review, the requested procedure is recommended at this time. This patient meets the criteria set forth in the Official Disability Guidelines (ODG) for a lumbar MRI. The patient has radiculopathy. It also appears that patient has progression of neurologic deficit since surgery in April of 2010. Patient also experienced falls in February xxxx that likely contributed to the progression of symptoms, including continued lower back pain with extension to the legs. Therefore, he does meet the criteria for an MRI, according to the ODG. Therefore, a lumbar MRI with and without contrast would be reasonable to help elucidate the cause of the progression of symptomatology.

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)