

SENT VIA EMAIL OR FAX ON
Jan/12/2012

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/11/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat Lumbar MRI with and without contrast

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

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Adverse determination letter 11/17/11

Adverse determination letter 12/14/11

Office notes Orthopedic Surgery Group 01/13/09-12/28/11 (various providers)

MRI lumbar spine 02/19/09

Preauthorization request form

Adverse determination letter 09/20/11

Adverse determination letter 01/29/09

PATIENT CLINICAL HISTORY SUMMARY

The injured employee was a male who sustained an injury to his low back when he was digging a trench and retaining wall collapsed on him. He complained of severe acute low back pain. Records indicate he underwent surgical intervention on 08/30/05 with bilateral hemilaminectomy and hemilaminotomy at L3-4 and L4-5, and left hemilaminectomy at L2-3. The patient reported moderate relief of low back pain following surgery. MRI of lumbar spine

performed on 02/19/09 reported multilevel degenerative changes with disc desiccation at L2-3, L3-4 and L4-5. At L2-3 there is anterior and posterior disc bulges with mild canal and left foraminal stenosis. At L3-4 there is disc bulge, mild hypertrophic changes in facet ligamentum flavum and minimal canal stenosis. At L4-5 there is mild disc bulge, hypertrophic changes of facet ligamentum flavum, and moderate canal stenosis without foraminal stenosis. At L5-S1 there is a mild disc bulge with hypertrophic changes in the facets and ligamentum flavum, with mild canal and bilateral foraminal stenosis. Dr. saw the claimant on 05/25/11 with complaints of moderate to severe back pain, with some radiation to buttocks and tingling in legs. The claimant is noted to be status post multilevel laminectomy without fusion. The claimant also underwent prostate surgery in 09/10. X-rays performed on this date including flexion / extension views showed some obvious lumbar instability with subluxation at L4-5 level with flexion and extension with possible posttraumatic degenerative instability. MRI from 2009 showed multiple changes. Diagnosis was postlaminectomy syndrome. Repeat MRI was recommended. Per adverse determination letter dated 09/20/11, it was noted that previous MRI showed disc bulges at L3-4, L4-5 and L5-S1 without nerve root entrapment. Dr. documented no new neurologic deficit objectively. Plain films were noted to reveal subluxation at L4-5 on flexion / extension views, but the excursion was not defined for individual motion. Further validation is needed. Claimant subsequently was seen on 11/02/11 with complaints of pain in the left lumbar spine radiating down the right leg to the toes with some numbness and tingling. Examination showed spasm in the back, reduced motion and tenderness. Neurologically the claimant was grossly intact, but limited ability to heel and toe walk on that side. Repeat MRI was recommended as the last one was done several years ago.

Per adverse determination letter dated 11/17/11, request for MRI of the lumbar spine with and without contrast was non-authorized. It was noted there was no documentation to indicate the presence of any new changes on neurological examination and Official Disability Guidelines would not support the request to be one of medical necessity.

Per adverse determination letter dated 12/14/11, appeal request for MRI of the lumbar spine with and without contrast was non-authorized. It was noted that an epidural steroid injection was authorized 06/05/09 at L5-S1. Evaluation on 11/23/11 documented low back pain, pain down the right leg, trouble with heel walk on the right side and toe walk on the right (less affected), positive straight leg raise at 45 degrees producing pain down the back and right leg. It was noted that Official Disability Guidelines provide that repeat MRI is not routinely recommended and should be reserved for significant change of symptoms and/or findings suggestive of significant pathology.

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

Based on the clinical information provided, the proposed repeat lumbar MRI with and without contrast is supported as medically necessary. The claimant sustained an injury to the low back on xx/xx/xx resulting in multilevel lumbar laminectomy performed in 2005. MRI of the lumbar spine performed 02/19/09 revealed disc bulges at L2-3, L3-4, L4-5 and L5-S1 with varying degrees of canal and foraminal stenosis. According to process notes from Dr., the claimant presented with increasing symptoms of moderate to severe pain in the back radiating all the way down into the right foot with numbness and tingling and weakness in the right leg. Dr. noted these are new signs which were verified by physical examination including positive straight leg raise on the right and some heel and toe walking weakness both verifying radicular signs, and a change from previous examinations. As such it appears that the claimant does meet medical necessity criteria for repeat MRI according to Official Disability Guidelines. Consequently the previous denials should be overturned on IRO.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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)