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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/10/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
MRI of the lumbar spine with contrast and with sedation

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Anesthesiology

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. The reviewer finds that medical necessity does not exist for MRI of the lumbar spine with contrast and with sedation.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Xx/xx/xx– Employers First Report Of Injury Or Illness
06/31/91 – Physical Therapy Note
07/01/91 – History And Physical
07/02/91 – MRI Lumbar Spine
07/05/91 – Consultation Report –MD
07/08/91 – Discharge Summary
07/11/91 – Consultation Report –MD
07/19/91 – Clinical Note –MD
03/08/92 – Initial Medical Report
03/09/92 – Procedure Note
03/09/92 – Clinical Note –MD
10/16/92 – Clinical Note –MD
04/07/93 – Clinical Note –MD
02/04/94 – Clinical Note –MD
06/02/94 – Clinical Note –MD
01/31/95 – Clinical Note –MD
11/29/95 – Clinical Note –MD
11/18/96 – Clinical Note –MD
03/17/97 – Clinical Note –MD
03/24/97 – MRI Lumbar Spine
01/21/98 – Clinical Note –MD
07/07/98 – Clinical Note –MD
01/04/99 – Clinical Note –MD
02/11/99 – Clinical Note –MD

02/01/00 – Clinical Note –MD
08/21/00 – Clinical Note –MD
09/05/01 – Clinical Note –MD
09/04/02 – Clinical Note –MD
02/11/04 – Clinical Note –MD
05/24/04 – Clinical Note –MD
06/23/04 – Clinical Note –MD
07/07/04 – Clinical Note –MD
08/06/04 – MRI Lumbar Spine
08/09/04 – Clinical Note –MD
09/09/04 – Clinical Note –MD
09/16/04 – Clinical Note –MD
10/12/04 – Procedure Note
10/21/04 – Clinical Note –MD
12/08/04 – Clinical Note –MD
01/10/05 – Procedure Note
06/07/05 – Clinical Note –MD
09/06/05 – Clinical Note –MD
10/28/05 – Clinical Note –MD
11/28/05 – Clinical Note –MD
12/20/05 – Clinical Note –MD
02/13/06 – Clinical Note –MD
07/17/06 – Clinical Note –MD
06/06/07 – Clinical Note –MD
04/24/08 – Clinical Note –MD
06/17/09 – Clinical Note –MD
06/22/09 – Emergency Room Report
05/20/10 – Clinical Note – MD
12/16/10 – Clinical Note –MD
06/15/11 – Emergency Room Report
06/21/11 – Clinical Note –MD
06/22/11 – Clinical Note –PA-C
07/07/11 – Operative Report
07/18/11 – Clinical Note –PA-C
08/17/11 – Clinical Note –PA-C
09/14/11 – Clinical Note –PA-C
11/03/11 – Functional Capacity Evaluation
11/18/11 – Clinical Note –PA-C
12/22/11 – Clinical Note –PA-C
01/20/12 – Clinical Note –PA-C
02/09/12 – Clinical Note –MD
02/10/12 – Clinical Note –PA-C
03/21/12 – Clinical Note –PA-C
04/18/12 – Clinical Note –PA-C
04/18/12 – Utilization Review Determination
04/27/12 – Correspondence –PA-C
05/04/12 – Utilization Review Determination

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who sustained a lifting injury to the low back in xxxx. The claimant was seen for evaluation. He complained of low back pain with radiation into the left posterior thigh and calf. Physical exam revealed the cranial nerves were intact. There was full strength of the upper and lower extremities. The deep tendon reflexes were diminished in the ankles. Sensation was intact. Straight leg raise was negative bilaterally. There was muscle spasm of the left paraspinous region. The claimant was assessed with chronic low back pain with exacerbation secondary to heavy lifting. The claimant was recommended for MRI of the lumbar spine. The claimant was seen regularly from 1991 through September 2011. MRI of the lumbar spine performed 07/02/91 revealed a herniated nucleus pulposus at L5-S1 with subtle leftward lateralization producing only minimal mass effect. There was mild

degenerative disc disease at L5-S1 with slight desiccation, minimal narrowing of the disc space, and mild annular bulge at the anterior aspect of the inner space.

MRI of the lumbar spine performed 03/24/97 revealed an unchanged central disc protrusion at L5-S1. There was no significant disc protrusion throughout the rest of the lumbar spine. MRI of the lumbar spine performed 08/06/04 revealed curvature convex right in the proximal lumbar spine that contacted the distal lumbar spine.
At L4-5, there was shallow broad-based annular bulging and mild facet hypertrophy. At L5-S1, there was disc degeneration and disc height loss. There were discogenic endplate irregularities seen, including posterior osteophytic ridging. There was superimposed broad-based disc bulging. There was mild central stenosis. There was severe right and moderate left foraminal narrowing, which could affect the exiting L5 nerve roots. The claimant underwent bilateral L5 lumbar transforaminal epidural steroid injections on 10/12/04. The claimant underwent bilateral L5 lumbar transforaminal epidural steroid injections on 01/10/05. The claimant underwent a left L4, L5, S1 medial branch block on 07/07/11. A functional capacity evaluation performed 11/03/11 placed the claimant in the sedentary physical demand level.

The claimant was seen for evaluation on 11/18/11. The claimant complained of low back pain with radiation to the bilateral posterior thighs. There was associated weakness of the knees, legs, back, and hips. Physical exam revealed full strength of the lower extremities. Lumbar range of motion was restricted with pain. There was pain with straight leg raise bilaterally. The claimant was assessed with low back pain. The claimant was prescribed Oxycontin. The claimant was seen for follow up on 04/18/12. The claimant complained of low back pain with radiation to the bilateral posterior thighs. There was associated numbness of the toes and weakness of the back. Physical exam revealed weakness of the lower extremities. There was spasm of the paravertebral muscles. There was tenderness to palpation of the paravertebral muscles and lumbar facets. Lumbar range of motion was restricted with pain. Straight leg raise caused pain bilaterally. The claimant was assessed with low back pain, displacement of intervertebral disc without myelopathy, degeneration of intervertebral disc, and chronic pain syndrome. The claimant was recommended for MRI of the lumbar spine. The request for MRI of the lumbar spine with contrast and sedation was denied by utilization review on 04/18/12 due to lack of objective documentation regarding the claimant's response to conservative treatment. The previous MRI report was not provided for review. There was no evidence of progressive deficits. The request for MRI of the lumbar spine with contrast and sedation was denied by utilization review on 05/04/12 due to no objective documentation or exhaustion or failure of medications, as well as other conservative.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Based on the medical records provided for review and current evidence based guideline recommendations -- the requested MRI of the lumbar spine with contrast and with sedation, is not medically necessary. The claimant underwent prior MRI studies in 2004 and the subsequent physical exams do not demonstrate any significant neurological changes or new deficits that would reasonably require new MRI studies under the guidelines. Medical records from 1991 through 2011 were reviewed. These records do not provide any information regarding recent conservative treatment or objective evidence of significant neurological changes or new deficits. The ODG states that repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The reviewer finds that medical necessity does not exist for MRI of the lumbar spine with contrast and with sedation.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)