

# I-Decisions Inc.

An Independent Review Organization  
5501 A Balcones Drive #264  
Austin, TX 78731  
Phone: (512) 394-8504  
Fax: (207) 470-1032  
Email: manager@i-decisions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jun/18/2012

**IRO CASE #:**

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

Repeat MRI Lumbar with and without contrast

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

M.D., Board Certified 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**

Official Disability Guidelines

MRI lumbar spine without contrast dated 11/08/10

Progress notes Dr. dated 11/16/10-04/30/12

Lumbar epidural steroid injection dated 12/01/10

Procedure note and hospital records dated 01/05/11

Radiographic report lateral lumbar spine 01/05/11

Neurophysiological monitoring report 01/05/11

Concentra progress notes 02/08/11-08/08/11

Manual muscle strength testing and range of motion testing dated 03/31/11-04/12/12

MRI lumbar spine without contrast dated 04/27/11

Initial Office visit and progress notes M.D. dated 05/10/11-05/27/11

MRI lumbar spine with and without contrast dated 05/23/11

Statement of medical necessity dated 05/27/11

Medical Center MMI and impairment rating dated 06/07/11

Report of medical evaluation dated 06/07/11

Functional capacity evaluation report dated 07/06/11

Electrodiagnostic testing dated 08/23/11

Report of medical evaluation and impairment rating dated 09/16/11

History and physical 11/03/11

Clinic notes the Back and Neck Clinic dated 11/03/11-04/03/12

Required medical examination dated 11/11/11

Medication monitoring report dated 11/30/11

Anesthesia record 02/20/12

Utilization review determination dated 04/19/12

Utilization review determination dated 05/10/12

Carrier submission 06/01/12

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who sustained a lifting injury on xx/xx/xx. He complains of low back

pain radiating to the right greater than left lower extremity. MRI of the lumbar spine on 11/08/10 revealed a large extruded disc at the L4-5 level. On 01/05/11 the claimant underwent right L4-5 laminotomy and discectomy with decompression of the right L5 nerve root. Following surgery the claimant participated in post-operative physical therapy but continued to complain of low back pain radiating to the lower extremities. Repeat MRI of the lumbar spine was performed on 04/27/11 and revealed post-surgical changes at the L4-5 level. Radiologist was unable to tell if there was residual disc or scar given the lack of IV contrast on the study.

An MRI of the lumbar spine with and without contrast on 05/23/11 reported multilevel stenosis and nerve root compromise most notably at L2-3, L3-4 and L4-5. Electrodiagnostic testing performed 08/23/11 reported evidence of chronic denervation changes primarily affecting the right L5 enervated muscles consistent with chronic L5 radiculopathy. There was no evidence of acute enervation; no abnormality in the left lower extremity; no evidence of peripheral neuropathy. Per designated doctor evaluation performed 09/16/11 the claimant was determined to have reached maximum medical improvement as of that date with 10% whole person impairment. The claimant was noted to complain of increasing back pain with radiation down both legs. He underwent pain management and received two epidural steroid injections. Repeat MRI scan was requested.

The request for repeat MRI of the lumbar spine with and without contrast was denied on utilization review dated 04/19/12. It was noted that the claimant is status post laminotomy, discectomy right L4-5 with decompression right L5 nerve root 01/05/11. He continued with low back pain and subsequently underwent caudal epidural steroid injections. The first gave some relief but pain became worse since the second injection. Examination dated 04/12/12 noted some reduction in range of motion, but no motor weakness was detected. Noting there was no evidence of progressive neurologic deficit or significant change of symptoms, medical necessity was not established for repeat lumbar MRI and the request was non-certified.

A reconsideration request for repeat MRI of the lumbar spine with and without contrast was reviewed on 05/10/12, and again the request was non-certified as medically necessary. It was noted that the claimant had MRI in 11/10 that showed a large disc extrusion at L4-5 with impingement on the L5 nerve root. The claimant is status post lumbar decompressive surgery on 01/05/11. He was seen on 04/30/12 with increasing back pain with radiation down both legs. He underwent pain management and received two epidural steroid injections. Examination showed well-healed midline incision. Flexion was 25 degrees. There is intense pain with straight leg raise. Strength was normal. There was no evidence of progressive neurologic deficit or significant change in symptoms and medical necessity is not established for repeat MRI of the lumbar spine.

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

The claimant sustained a lifting injury to the low back. He complained of low back pain radiating to the right greater than left lower extremity. An MRI showed a large disc extrusion at L4-5 with impingement of the left L5 nerve root, and the claimant underwent decompressive surgery performed 01/05/11. He continued with complaints of low back pain with radiation down both legs. Records indicate he underwent pain management and received two epidural steroid injections. Examination showed pain with straight leg raise; normal strength; flexion 25 degrees. The records indicate the claimant has undergone repeat MRI studies including MRI with and without contrast on 05/23/11 and electrodiagnostic testing on 08/23/11. Per ODG guidelines, repeat MRI of lumbar spine is not routinely recommended and should be limited to patients who have significant change in symptoms with findings suggestive of significant pathology. There is no evidence of progressive neurologic deficit or significantly changed symptoms. The reviewer finds there is not a medical necessity at this time for Repeat MRI Lumbar with and without contrast. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

**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)