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Notice of Independent Review Decision

DATE OF REVIEW: 06/14/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient MRI without contrast on the lumbar spine

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

Board Certified in Family Practice.

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. 09/01/10 – Radiographs Lumbar Spine
2. 09/23/10 – Electrodiagnostic Studies

3. 09/28/10 – Clinical Note –DO
4. 10/15/10 – Clinical Note –DO
5. 10/28/10 – MRI Lumbar Spine
6. 11/15/10 – Clinical Note –DO
7. 12/06/10 – Clinical Note –DO
8. 01/17/11 – Clinical Note –DO
9. 02/08/11 – Clinical Note –DO
- 10.02/28/11 – Clinical Note –DO
- 11.05/02/11 – Clinical Note –DO
- 12.08/09/11 – Clinical Note –DO
- 13.11/30/11 – Clinical Note –DO
- 14.12/28/11 – Clinical Note –MD
- 15.12/29/11 – Physical Therapy Note
- 16.01/09/12 – Physical Therapy Note
- 17.01/12/12 – Physical Therapy Note
- 18.01/16/12 – Physical Therapy Note
- 19.01/18/12 – Physical Therapy Note
- 20.01/19/12 – Physical Therapy Note
- 21.01/23/12 – Physical Therapy Note
- 22.02/08/12 – Clinical Note –MD
- 23.02/14/12 – MRI Order Form
- 24.02/14/12 – Utilization Review Determination
- 25.03/08/12 – Clinical Note –MD
- 26.04/24/12 – Medical Record Review –MD
- 27.05/07/12 – Clinical Note –MD
- 28.05/23/12 – Utilization Review Determination

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male with complaints of low back pain. Electrodiagnostic studies performed 09/23/10 were unremarkable with evidence of acute or chronic denervation. The claimant saw Dr. on 10/15/10 with complaints of low back pain. Physical exam revealed pain to palpation of the mid to low back. Straight leg raise was reported to be questionable. Neurologic exam was non-focal. The claimant was assessed with dysesthesias and lumbar sprain. MRI of the lumbar spine performed 10/28/10 revealed a disc bulge at T11-12. At L4-5, there was a right paracentral-right posterolateral disc protrusion that produced mild right lateral recess stenosis. At L5-S1, there was a far right lateral–right neural foraminal osteophyte or disc extrusion. The right L5-S1 neural foramen was moderately stenotic. The claimant saw Dr. on 02/08/12 with complaints of low back pain rating 3 out of 10. Physical exam revealed full range of motion with pain. There was full strength of the lower extremities. There was tenderness to palpation over the lumbar paraspinal muscles, left sacroiliac joint, and left latissimus dorsi. There was no muscle spasm noted. The lower extremity reflexes were symmetric

bilaterally. Straight leg raise was negative bilaterally. FABER test reproduced pain over the left sacroiliac joint. Sensation was intact. The claimant was assessed with lumbago, lumbosacral sprain, muscle spasm, lumbar sprain, and lumbar disc displacement. The claimant was recommended for MRI of the lumbar spine. The request for MRI of the lumbar spine was denied by utilization review on 02/14/12 due to no objective evidence of progressive neurological deficits.

The claimant saw Dr. on 03/08/12 with complaints of low back pain rating 3 out of 10. Physical exam revealed full range of motion with pain. There was full strength of the lower extremities. There was tenderness to palpation over the lumbar paraspinal muscles, left sacroiliac joint, and left latissimus dorsi. There was no muscle spasm noted. The lower extremity reflexes were symmetric bilaterally. Straight leg raise was negative bilaterally. FABER test reproduced pain over the left sacroiliac joint. Sensation was intact. The claimant was assessed with lumbago, lumbosacral sprain, muscle spasm, lumbar sprain, and lumbar disc displacement. The claimant was prescribed Lyrica and Ultracet. The claimant saw Dr. on 05/07/12 with complaints of low back pain. Physical exam revealed full range of motion with pain. There was full strength of the lower extremities. There was tenderness to palpation over the lumbar paraspinal muscles, left sacroiliac joint, and left latissimus dorsi. There was no muscle spasm noted. The lower extremity reflexes were symmetric bilaterally. Straight leg raise was negative bilaterally. FABER test reproduced pain over the left sacroiliac joint. There was decreased sensation to light touch over the left L5 dermatome. The claimant was assessed with lumbago, lumbosacral sprain, muscle spasm, lumbar sprain, and lumbar disc displacement. The claimant was recommended for MRI of the lumbar spine. The request for MRI of the lumbar spine was denied by utilization review on 05/23/12 due to no objective evidence of neurologic deficits, progressive clinical worsening, or radiculopathy.

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

The requested repeat MRI of the lumbar spine is not medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The initial MRI study revealed a far right disc protrusion at L5-S1. The claimant's physical exams did not reveal any significant progressive findings in the lower extremities that would reasonably require repeat MRI studies. The claimant is noted to have subjective decreased sensation in the left L5 dermatome; however, no other significant findings to include myotomal weakness or loss of reflexes were noted that would reasonably support new MRI studies. As the clinical documentation provided for review does not meet guideline recommendations for the requested service, the prior denials are upheld.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

REFERENCES:

1. Official Disability Guidelines, Online Version, Low Back Chapter. 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).