



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 5/1/2012

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of an MRI of the lumbosacral spine.

**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 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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of an MRI of the lumbosacral spine.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
MD, and Patient

These records consist of the following (duplicate records are only listed from one source): Records reviewed.: MD: Script – 3/1/12, EMG/NCS Report – 4/3/12, LHL009 – 4/14/12; and. Notices of Utilization Review Findings – 3/12/12 & 4/11/12.

Records reviewed MD: MD, PA - EMG/NCS summary report – 4/3/12; MD - Office Note – 4/3/12, Script – 4/3/12, and Neurologic Consultation – 3/1/12.

Records reviewed from Patient: Letter from Patient – 4/26/12; MD - Neurologic Consultation – 4/3/12; Dr. -Interventional Pain Management – 3/5/12; and P.A.-C. and MD - Letter of Medical Necessity – 4/19/12.

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant was noted to have been injured whilst lifting a bag of coins. An MRI revealed disc bulges and neuroforaminal narrowing at L4-5 and L5-S1. An EMG/NCV was negative. On 3/1/12, there was low back pain with left-sided radiation to the knee level. There was a normal examination of the lower extremities regarding motor power and reflexes, guarding of the examination including straight leg raising assessment, and complaints of hyperesthesias to the left leg below the knee (excluding the foot). On 4/3/12, electrical studies revealed increased symptoms over a two year period and “sciatic irritation” with chronic left L5 radiculopathy. The sensory examination was “non-focal.” The 4/19/12 dated letter of appeal was reviewed. Prior treatments have included medications, therapy and at least one ESI with 80% pain reduction.

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

With increased symptoms and a documented progression in electrical studies, the requested lumbar MRI is medically necessary. Occult and chronic nerve root impingement (such as with an extruded disc) is a possibility and the request is appropriate and meets clinical guidelines. As noted in ODG, “Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit.” Having failed such conservative treatment and with plausible radiculopathy, the MRI is medically necessary at this time.

**ODG Lumbar Spine- MRI:**

Indications for imaging -- Magnetic resonance imaging:

- Thoracic spine trauma: with neurological deficit
- Lumbar spine trauma: trauma, neurological deficit
- Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit)
- Uncomplicated low back pain, suspicion of cancer, infection, other “red flags”
- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit.
- Uncomplicated low back pain, prior lumbar surgery
- Uncomplicated low back pain, cauda equina syndrome
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, painful
- Myelopathy, sudden onset
- Myelopathy, stepwise progressive

**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)