

CASEREVIEW

8017 Sitka Street
Fort Worth, TX 76137

Phone: 817-226-6328
Fax: 817-612-6558

Notice of Independent Review Decision

DATE OF REVIEW: April 26, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
MRI Lumbar without contrast

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board Certified in Family Medicine with over 13 years of experience.

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:

02/24/12: Follow-up Evaluation by MD
03/01/12: UR performed by MD
03/13/12: Follow-up Evaluation
03/21/12: UR performed MD

PATIENT CLINICAL HISTORY [SUMMARY]:

On February 24, 2012, the claimant was re-evaluated by MD for her back strain, right hip and right injury she sustained after a fall on xx/xx/xx. It was reported she had physical therapy 5 times with 50% improvement. She complained of pain in her right knee rated 6/10 and pain in her lower back rated a 7/10. There was no radiation of pain, but she still had some right hip pain rated a 5/10. On physical examination of her lumbar spine she was unable to walk on toes or heels. She had decreased active range of motion in all directions. She had intense pain tenderness of the midline L-spine at the level of L4, L5 and S1 and the paraspinous muscles at those levels. Reflexes were symmetric. SLR was positive at 70 degrees. EHLs normal. Moderate limp noted. The right knee joint was stable. No crepitus on motion. No deformity. The claimant could not squat and walked with a moderate limp. No popliteal fossa swelling. No locking or giving way. No knee effusion. She had decreased active ROM of the right hip in all directions with pain tenderness over the hip joint. Diagnosis: 1. Knee contusion. 2. Buttock contusion. 3. Contusion of the lumbar region. 4. Lower leg contusion. 5. Hip contusion. 6. Hip/pelvic pain. Plan: Refilled Ultram 50 mg. Continue with previous therapy schedule, 3 times a week for 2 weeks. MRIs ordered of the lumbar spine, right hip and right knee.

On March 1, 2012, MD performed a UR on the claimant. Requested services: MRI Lumbar without contrast, MRI right hip, MRI right knee. Rationale for Denial: Based upon review of Dr. note 2/24/12, confirm no neurologic deficit, contradictory information regarding straight leg raise/radicular signs, hip and knee exams are not specific regarding suspected injury/pathology. Dr. agrees that there is lack of clinical information to support MRI of any of the body parts. Deny MRIs of lumbar, right knee and right hip given lack of clinical information to support imaging by ODG criteria.

On March 13, 2012, the claimant was re-evaluated by PA-C who reported worsening of symptoms with worsening of back and knee pain. Her lower back pain was rated 9/10 and 5/10 for the right knee. She reported improvement of her right hip. She also reported radiation of back pain into the right leg and numbness in the left great toe. The claimant reported popping, giving way and numbness to the right knee but denied weakness or locking. She had been wearing a right knee splint. She had completed 6 sessions of PT with some improvement. On physical examination there was some soft tissue tenderness to right mid and lower lumbar spine. She had full ROM with pain and positive straight leg raise on the right. She had mild joint effusion, tenderness to medial and lateral joint line of the right knee. Full ROM with pain, normal gait, positive patellar grind, and positive McMurrays. Diagnosis: 1. Contusion of lumbar region. 2. Back pain. 3. Knee strain. 4. Knee pain. Plan: Refill Ultram 50 mg, continue physical therapy, placed on modified activity and refer for MRI of the lumbar spine and right knee.

On March 21, 2012, MD performed a UR on the claimant. Requested services: MRI Lumbar without contrast and MRI right knee. Determination: MRI of the right

knee was approved; the MRI of the lumbar was not approved. Rationale for Denial: The MRI of the lumbar is not medically indicated in the absence of neurologic deficits.

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

Decisions are upheld. Documentation is not consistent with ODG guidelines for ordering a Lumbar MRI. The claimant has no prior surgical history of the low back and no neurological findings. The request for a Lumbar MRI without contrast is not found to be medically necessary.

PER ODG:

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
- Myelopathy, slowly progressive
- Myelopathy, infectious disease patient
- Myelopathy, oncology patient

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)