

# True Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Aug/27/2012

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

Outpatient repeat MRI of the Lumbar Spine with and without contrast

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

Orthopedic spine 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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.**

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines

Request for IRO dated 08/10/12

Utilization review determination 08/06/12

Utilization review determination 08/09/12

MRI lumbar spine 06/22/11

Clinical record 11/16/11-06/07/12

Clinic note 06/22/12-07/31/12

Procedure report facet injections dated 07/17/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who is reported to have sustained work related injuries on xx/xx/xx. On the date of injury she is reported to have had sudden onset of back and left leg pain while walking down a hall. Per the available data, the claimant is status post decompressive laminectomy at L5-S1 performed on 11/16/04.

The record includes MRI of lumbar spine dated 06/22/11 which notes disc desiccation at L3-4 with central disc protrusion that results in severe canal stenosis. At L4-5 there is disc desiccation with broad based posterior disc protrusion, mild facet arthropathy with severe canal stenosis and mild to moderate right neural foraminal narrowing. At L5-S1 there is disc space narrowing with desiccation of the disc. No posterior disc bulge or protrusion is seen. There is mild bilateral facet arthropathy left greater than right with mild to moderate left foraminal narrowing.

Records indicate the claimant was seen in follow-up by on 11/16/11. It is noted the claimant was seen by who felt he could help with surgery. This is reported to be extensive fusion from L3 to the sacrum. She is noted to not be taking any medications and is working full duty. Her physical examination is grossly unremarkable and claimant reports a tingling dysesthesia down left leg in a nondermatomal pattern. She was provided Tramadol and Neurontin.

Records indicate the claimant was seen in periodic follow-up and continued on oral medications. She made no substantive improvements with oral medications. On 04/03/12 she is reported to have marked decreased sensation in left S1 distribution.

The claimant was seen by on 06/22/12. It is noted she has previously been seen by surgeon who recommended a three level fusion. There was discussion regarding artificial disc replacement. The claimant notes she had a family member who had fusion and had progressive disease on top of fusion. On physical examination, the claimant is noted to be six feet tall weighs 215 pounds. Reflexes are reported to be hyperactive at the knees and ankles bilaterally, motor strength is intact, sensory is intact, and pain with attempted extension of lumbar spine. She subsequently is recommended to undergo facet injections at L3-4 and L4-5. Radiographs performed at this visit are reported to show near complete collapse of the L5-S1 disc space, no spondylolisthesis, and normal lumbar lordosis.

On 07/17/12, the claimant underwent lumbar facet injections bilaterally at L3-4 and L4-5. Post-operatively the claimant was seen in follow up on 07/31/12. It is reported that her post procedure pain log showed no drop in her pain level even during the anesthetic phase. There is a discussion regarding lumbar discography. The claimant is recommended to undergo a repeat MRI and she was provided refills of her oral medications.

The initial review was performed by on 08/06/12. non-certified the initial request. He notes that last MRI was in 06/20/11 and showed degenerative changes. He notes that there is no documentation of a progression of neurological signs or symptoms and therefore the request does not meet criteria for repeat imaging under Official Disability Guidelines.

The appeal request was reviewed by on 08/09/12. non-certified the appeal request. He notes that Official Disability Guidelines recommends repeat imaging studies with a history of worsening of condition or neurological deficits. He notes that the claimant's surgical history and medical records fail to adequately document if the claimant's current findings are significantly worse than what has been ongoing or if there is new focal neurological deficit that was not previously present. subsequently non-certified the request.

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

The request for outpatient repeat MRI of the lumbar spine with and without contrast is not supported as medically necessary and the prior utilization review determinations are upheld. The submitted clinical records indicate that the claimant has a history of low back pain with radiation to the left lower extremity without a significant precipitating event. The claimant has previously undergone imaging of the lumbar spine which indicated the presence of stenosis at L3-4 and L4-5 and the claimant is reported to have collapse of the disc space at L5-S1. The claimant has no substantive progressive or progressive neurologic findings on physical examination. She essentially has chronic axial back pain and in the absence of a progressive neurological deficit repeat MRI is not clinically indicated or supported under Official Disability Guidelines.

#### **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)