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Notice of Independent Review Decision

DATE OF REVIEW: 9/19/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity 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

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 agrees with the previous adverse determination regarding the prospective medical necessity MRI of the Lumbar Spine with and without Contrast.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Texas Department of Insurance

These records consist of the following (duplicate records are only listed from one source):

Records reviewed from

Denials- 8/16/12, 8/31/12

Daily Treatment Notes- 9/8/10, 9/3/10, 9/2/10, 8/31/10

Initial Treatment Plan-7/22/10
Initial Evaluation-Lumbar- 8/18/10
Physical Therapy Rx- 8/16/10
Procedure Order- 8/10/12
Office Notes- 8/28/12, 8/13/12, 3/5/12, 12/5/11, 8/22/11, 6/28/12
Letter- 5/23/11, 8/29/12
Report of Procedure- 6/24/10
Electromyography Report- 11/13/09
MRI Lumbar Spine- 5/14/09
Impairment Letter- 12/21/10
Review of Medical History & Physical Exam- 12/17/10
Texas Workers' Compensation Commission
Report of Medical Evaluation- 12/17/10
Letter- 7/21/11

All records reviewed were duplicates

Records reviewed from Texas Department of Insurance
Intake paperwork

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

PATIENT CLINICAL HISTORY [SUMMARY]:

Records were received and reviewed. The mechanism of injury was that the worker was injured. Electrical studies dated 11/13/2009 revealed right S1 radiculopathy. A lumbar MRI dated 5/14/2009 revealed a central to left sided disc protrusion at L3-4 and lateral recess compromise, a central to right-sided protrusion was noted at L5-S1 with contact of the S1 nerve root. The past history includes a right-sided hemilaminectomy at the right L5-S1, lateral recess decompression and foraminotomy on 6/24/2010. There was ongoing low back pain with recurrent sciatica into the lower extremities. There were also complaints of numbness, tingling and weakness in the legs. The neurologic exam was not provided, nor were other examination findings. Denial letters discussed the lack of 'red flag' neurologic abnormalities, x-ray report and or recent trial and failure of conservative treatments.

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

Recommended denial of requested services. Without an abnormal neurologic examination and without evidence that the neurological condition has any apparent 'red flags' indicative of progression; applicable clinical guidelines do not support a repeat MRI of the lumbar spine at this time. In addition, the lack of provision of any recent comprehensive conservative therapy also does not meet guidelines for the request. Therefore, the current request is not medically reasonable or necessary at this time.

Reference: 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
- 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)