

Core 400 LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/28/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

outpatient lumbar MRI with and without contrast as related to the lumbar spine

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

M.D., Board Certified Orthopedic surgeon

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. The reviewer finds that medical necessity does not exist for outpatient lumbar MRI with and without contrast as related to the lumbar spine.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Operative reports 05/11/94 and 03/01/02
Clinical notes 06/17/93-05/24/12
Radiology reports lumbar spine 05/11/94-02/03/03
MRI lumbar spine 12/26/96-02/08/07
CT myelogram lumbar spine 11/20/01-09/28/10
Urology consult 07/27/00
Procedure notes 03/01/02-01/07/09
Prior reviews 06/04/12 and 06/08/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who has been followed for a long history of low back pain. She is status post lumbar fusion from L4 to S1. MRI studies from 2007 showed no evidence of significant structural changes within the fusion graft. A lumbar CT myelogram was completed on 09/28/10, which revealed disc space narrowing at L4-5 and L5-S1, which were fused. The vertebral body heights were maintained and there was mild disc bulging at L3-4 narrowing the inferior aspect of the neural foramina. Disc osteophyte complexes at L5-S1 were present. Some neuroforaminal narrowing to the right at L5-S1 was noted. The patient was recommended for repeat CT myelogram studies in 11/11 and the patient continued to have significant pain. Recent medications or medications as of May of 2012 included Motrin and Ultram. The patient continued to report increased numbness dyesthesia and weakness in the lower extremities, and CT myelogram studies were recommended on 05/24/12 for pre-

operative planning. No physical examination findings were provided for review. The request for lumbar MRI was denied by utilization review on 06/04/12 as there was no evidence of progression of neurological deficits. The request for MRI of the lumbar spine was again denied by utilization review on 06/08/12 due to no updated physical examination findings of progressive neurological deficits.

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

This patient has had a long history of low back pain and has undergone prior fusion from L4 to S1. The medical records demonstrate that the patient continues to have severe unrelenting pain in the lumbar spine, and opinion is that the patient had clinical instability at L3-4. The most recent CT myelogram studies of the lumbar spine failed to document any significant motion segment instability at L3-4, and there are no recent physical examination findings for the patient demonstrating a severe progressive neurological deficit that would reasonably support updated MRI studies at this time. Additionally, given the extent of the patient's hardware in the lumbar spine this would produce significant artifact defects in the MRI study, which would reasonably impact the quality of the study. Metallic hardware in the lumbar spine is a contraindication for MRI studies and other MRIs and other imaging studies would reasonably be more appropriate for the patients. As the clinical documentation provided for review does not meet ODG recommendations, the reviewer finds that medical necessity does not exist for outpatient lumbar MRI with and without contrast as related to the lumbar spine.

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)