

# Icon Medical Solutions, Inc.

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## Notice of Independent Review Decision

**DATE:** November 27, 2013

**IRO CASE #:**

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

MRI Lumbar W/O Contrast, Repeat

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

The reviewer is certified by the American Board of PM/Occupational Medicine with over 34 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 medical necessity exists for each of the health care services in dispute.

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

02/18/13: Office visit  
04/10/13: Procedure Note  
07/16/13: Addendum  
08/07/13: Referral  
08/13/13: Preauthorization Request  
09/04/13: UR performed  
10/03/13: Followup visit  
10/16/13: Referral  
10/17/13: Preauthorization Request  
10/22/13: UR performed

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who hit his ribs while working on xx/xx/xx.

02/18/13: The claimant was evaluated for low back pain associated with radiating pain down the left leg. It was noted that he had been treated with therapy but had not yet had an epidural steroid injection. On exam, flexion was 45 degrees. He

had pain with straight leg raising on the left side at 30 degrees but had no pain on the right side. There was normal strength in the iliopsoas, quadriceps, and tibialis anterior. There was weakness in the left extensor hallucis longus. MRI report dated 07/20/12 described retrolisthesis of L5 on S1 with a posterior annular tear at L5-S1. There was bilateral foraminal narrowing at L5-S1. EMG report dated 09/25/12 did not confirm radiculopathy. The plan was to have an epidural steroid injection.

04/10/13: Procedure report. POSTOPERATIVE DIAGNOSIS: Lumbar radiculopathy with nerve root dysfunction. PROCEDURE: Lumbar Interlaminar Epidural Steroid Injection at L5-S1.

07/16/13: submitted an addendum to Designated Doctor Evaluation performed on 12/07/12. noted that the annular tear was not compensable. Impairment rating was 5% whole person impairment based on physical exam.

08/07/13: A request was made for a lumbar spine MRI scan without contrast with a diagnosis code of 847.2.

09/04/13: UR performed. RATIONALE: The last medical note is from February 2013 and it mentions nothing about the necessity for a repeat lumbar MRI. The patient has had prior lumbar MR imaging and lumbar anatomy and pathology have been well defined. There is no evidence of a progression of a neurological deficit or a change on the patient's presentation.

10/03/13: The claimant was reevaluated. There continued to be decreased range of motion with only 35 degrees of flexion. He still had pain with straight leg raising on the left side at 30 degrees. There was normal strength in the iliopsoas, quadriceps, and tibialis anterior; but there was grade 4/5 weakness in the left extensor hallucis longus. He had decreased sensation in the left L5 dermatome. It was noted that another request would be made for an MRI scan, specifically for surgical planning. It was noted that he was a surgical candidate and had experienced progressive neurologic change.

10/22/13: UR performed. RATIONALE: ODG Guidelines do not recommend repeating an MRI unless there is a significant change that is suggestive of significant pathology. There is no evidence of a significant change in the claimant's condition that would support the need for repeat imaging. There are no current clinical notes. The request for a repeat MRI is not consistent with ODG recommendations.

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

The previous adverse determinations are upheld. ODG Guidelines do not recommend repeating an MRI unless there is a significant change that is suggestive of significant pathology. There is no evidence of a significant change in the claimant's condition that would support the need for repeat imaging.

Furthermore, a repeat MRI would not change the course of treatment for this claimant as additional information would not be provided that would change the plan of treatment for this claimant. There is sufficient clinical information and information provided from the initial MRI to form a plan of care for this claimant without additional exposure to radiation and procedures. ODG does not support additional procedures for this claimant and a repeat MRI is therefore not medically necessary.

**ODG:**

<p>MRIs (magnetic resonance imaging)</p>	<p><b><u>Indications for imaging</u> -- Magnetic resonance imaging:</b></p> <ul style="list-style-type: none"> <li>- Thoracic spine trauma: with neurological deficit</li> <li>- Lumbar spine trauma: trauma, neurological deficit</li> <li>- Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit)</li> <li>- Uncomplicated low back pain, suspicion of cancer, infection, other “red flags”</li> <li>- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit.</li> <li>- Uncomplicated low back pain, prior lumbar surgery</li> <li>- Uncomplicated low back pain, cauda equina syndrome</li> <li>- Myelopathy (neurological deficit related to the spinal cord), traumatic</li> <li>- Myelopathy, painful</li> <li>- Myelopathy, sudden onset</li> <li>- Myelopathy, stepwise progressive</li> <li>- Myelopathy, slowly progressive</li> <li>- Myelopathy, infectious disease patient</li> <li>- Myelopathy, oncology patient</li> </ul>
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**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)**