

# True Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Feb/19/2013

**IRO CASE #:**

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

MRI of the Lumbar Spine

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

PM&R and Pain Medicine

**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 01/26/13  
Receipt of request for IRO 02/04/13  
Utilization review report 11/16/12  
Utilization review determination 11/19/12  
Utilization review report 12/28/12  
Utilization review determination 12/31/12  
Clinical records Dr. 11/02/12 and 12/28/12  
Clinical note Dr 11/14/12  
Radiographic report lumbar spine 11/21/12  
Radiographic report right knee 11/21/12  
Letter of appeal 11/26/12  
Treatment records 10/31/12-12/04/12  
Therapeutic exercise sheets 11/12/12-12/03/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who was reported to have sustained work related injuries on xx/xx/xx. On the date of injury, he was walking down a rocky slope when he slipped on the rocks. He lost his balance and twisted his back. His foot became stuck in the rocks causing him to twist his right knee. The claimant was treated conservatively with oral medications and physical therapy. At a follow up visit dated 11/02/12, the claimant had less low back pain and less pain in the right knee. Current medications included Mobic 7.5mg and Ultracet and the claimant received conservative treatment including neuromuscular reeducation and spinal manipulation.

On 11/14/12, the claimant was seen by Dr.. The claimant has intermittent pain and was treated with oral medications and physical therapy and had a history of prior back surgery. On physical examination, range of motion was 0-120 degrees and there was medial joint line tenderness and a reported positive McMurray test. The claimant was subsequently recommended to undergo MRI of the right knee.

The record included a radiographic report of the lumbar spine dated 11/21/12. This report indicates a mild retrolisthesis at the L4-5 level with displacement by approximately 3mm. The radiologist noted that there was a superior endplate irregularity with reduced height of the L5 vertebral body likely a result of prior trauma and there were no similar degenerative changes seen in the adjoining disc or L4 vertebral body and there was mild to moderate generalized spondylitic changes noted and there was a mild retrolisthesis at L4-5 with displacement by approximately 3mm which did not change in flexion or extension radiographs and there was a mildly reduced height at the L5-S1 intervertebral disc space. Radiographs of the right knee showed mild degenerative osteophytes at the medial tibial and lateral femoral condyles and the femorotibial joint space was maintained and there was evidence of patella alta and mild knee joint osteoarthritis.

The record included a letter of appeal dated 11/26/12 in which the requester Dr. reported that the claimant had positive Kemp test bilaterally and positive straight leg raise, positive apprehension test and motor strength was graded as 4- in the knee extensors 4- or 4- for foot eversion and inversion and 4- for dorsiflexion of the great toe on the right and motor strength on the left was intact and there was a reported and it was reported that there was a right L5 hypoesthesia. Dr. recommended the performance of MRI of the lumbar spine and MRI of the right knee.

The initial request was reviewed by Dr. on 11/16/12 who non-certified the request noting that Official Disability Guidelines indicate that an MRI of the lumbar spine would be supported for acute trauma with a neurological deficit, cases of myelopathy, cases of uncomplicated low back pain with radiculopathy when one month of conservative therapy had failed to relieve symptoms, and a severe progressive neurological deficit was noted. He noted that there was no indication of a myelopathy documented. Symptoms were not noted to be severe or progressive. He subsequently non-certified the request for the lumbar spine and right knee.

The appeal request was reviewed by Dr. on 12/28/12 who non-certified the request noting that Official Disability Guidelines recommend MRI for uncomplicated back pain accompanied by radiculopathy after at least one month of conservative therapy or sooner if severe or progressive neurological deficits appear and that the clinical documentation submitted lacked evidence of significant progressive neurological deficit or other indications of "red flags" that would warrant magnetic resonance imaging at that time. He further noted that there was a lack of clinical documentation regarding the request for MRI of the right knee.

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

The submitted clinical records indicate that the claimant is a male who developed low back pain as a result of a slip while descending an incline. The claimant has a history of previous back surgery. The submitted clinical records report that the claimant has had some improvement with physical therapy and had decreased pain levels. The claimant has positive

findings on physical examination which include motor strength weakness and evidence of a right L5 hypesthesia. The record does not provide any data which indicates that the claimant has objective evidence of a progressive neurological deficit. It is therefore the opinion of this reviewer based on the submitted clinical records that the request or that the previous denials were appropriate and therefore upheld.

**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)