

# Applied Assessments LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Dec/21/2012

**IRO CASE #:**

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

Outpatient lumbar MRI

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

Orthopedic Spine Surgeon, Practicing Neurosurgeon

**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 11/30/12  
Receipt of request for IRO dated 12/02/12  
Utilization review determination dated 10/22/12  
Utilization review determination dated 11/29/12  
Employer's 1st report of injury or illness dated 04/09/09  
MRI lumbar spine dated 06/17/11  
Procedure report spinal cord stimulator implant dated 10/31/11  
Clinical records dated 12/06/11, 01/10/12, 10/04/12, & 11/08/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who is reported to have sustained work-related injuries on xx/xx/xx. It is reported that he sustained an injury to his low back. The record includes a MRI of the lumbar spine dated 06/17/11. This study notes a broad 1 mm disc bulge at L2-3 and a 2 mm broad bulge at L3-4. At L4-5 posterolateral osteophytes are present on either side causing mild bilateral neural foraminal narrowing. There is evidence of a fusion at this level with no disc herniation or central canal stenosis. At L5-S1 there is evidence of prior surgery with fusion and central/left paracentral discectomy/post-surgical changes. There is non-enhancing disc material noted within each posterolateral area with associated mild to moderate bilateral neural foraminal narrowing surrounding the post-surgical changes. There are small perineural cysts present associated with the bilateral exiting S1 and S2 nerve roots. Records indicate that on 10/31/11, the claimant underwent implantation of a spinal cord

stimulator. It is reported that he received benefit from the implantation of the stimulator which provides coverage of his lower extremity pain; however, he continues to have low back pain. Records indicate that on 01/10/12, the claimant was doing well. He is working and feels that the stimulator has helped him. He continues to have some pain management needs.

On 10/04/12, the claimant was seen in follow-up. He is reported to have back pain and leg pain located on the left side. He has an implanted dorsal column stimulator and has prescriptions for Lyrica, Hydrocodone APAP, and Ambien. On physical examination he is 5'11" tall and weighs 180 lbs. His gait is balanced. He has tenderness over the paravertebral muscles. Lumbar range of motion is painful. Straight leg raise is normal on the right side and positive on the left at 15 degrees. Waddell's test shows non-specific tenderness, simulation/axial loading, distraction, seated straight leg raise, and regional disturbance and overreaction are absent. Left EHL peroneus strength is graded as 4/5. The claimant was subsequently recommended to undergo a repeat MRI. The claimant was seen in follow-up on 11/08/12. It is noted that MRI has been denied. The claimant still complains of pain and there are no changes in his examination.

The initial review was. opines that the request does not meet ODG criteria for repeat MRI in that the clinical provided does not show a progression of a neurologic deficit. No peer-to-peer was conducted.

On 11/29/12, the appeal request. He notes that there has not been submission of any current information in support of this request or contradicting the previous peer review recommendations. The records do not note the progression of a neurologic deficit which would support the performance of a repeat MRI of the lumbar spine.

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

The request for outpatient lumbar MRI is not supported as medically necessary. The submitted clinical records indicate that the claimant sustained an injury to his low back as a result of lifting. The claimant is noted to have undergone a prior 2-level fusion at L4-5 and L5-S1. The records indicate that the claimant ultimately developed failed back surgery syndrome and underwent permanent implantation of a dorsal column stimulator with benefit. Postoperatively, the claimant was maintained on oral medications and subsequently returned to work. The records as provided show no indication of a progressive neurologic deficit which would warrant reimaging per the official disability guidelines. At present, the claimant does not meet ODG criteria. Therefore, based on the clinical information provided, the prior utilization review determinations are upheld.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**