

Applied Assessments LLC

An Independent Review Organization
3005 South Lamar Blvd, Ste. D109 #410

Austin, TX 78704

Phone: (512) 772-1863

Fax: (512) 857-1245

Email: manager@applied-assessments.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Dec/21/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI Lumbar Spine

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 12/11/12

Receipt of request for IRO dated 12/12/12

Utilization review determination dated 11/01/12

Utilization review determination dated 12/10/12

Procedure report transforaminal ESI dated 10/01/03

Clinical note Dr. dated 01/26/05, 03/02/05

Procedure report transforaminal ESI dated 02/17/05

Letter Dr. dated 07/06/05

Peer review dated 06/17/11

Treatment records DC

Peer review report dated 05/11/12

Clinical note Dr. dated 10/16/12

Carrier submission dated 12/14/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who is reported to have sustained work-related injuries as a result of a motor vehicle accident occurring on xx/xx/xx. The submitted records indicate that the claimant sustained injuries to the neck and the low back. She is noted to have undergone conservative treatments which have included lumbar epidural steroid injections, chiropractic care, and physical therapy. The claimant is status post lumbar fusion from L4-S1. Her condition is noted to have exacerbated over time. She is currently diagnosed with failed back surgery syndrome. The claimant is also noted to be status post ACDF from C4-5 through C6-7. The records indicate that the claimant has largely been maintained on oral medications.

On 10/16/12, the claimant was seen by Dr.. The claimant has complaints of neck stiffness with low back pain and bilateral leg pain with numbness and tingling and has failed 18 years of conservative treatment. She is noted to be status post 2 cervical surgeries and surgery to the lumbar spine. It is reported that her back and bilateral leg pain are worsening, and she presents for consultation. Radiographs of the lumbar spine including flexion/extension views reveal laminotomy at L4-5 and laminectomy at L5-S1 with pedicle screws at L4, L5, and S1 bilaterally. There is plating with gross interior screw penetration of S1 through the anterior cortex greater than 3 threads. It is reported that there appears to be no posterior bone formation. There is no evidence of screw fracture. She is reported to have significant adjacent segment disease at L3-4 with a functional spinal unit collapse of 8 mm from the standing lateral and neutral film. She was opined to meet the clinical instability criteria per Official Disability Guidelines and she was noted to have post-surgical changes at C4-5, C5-6, and C6-7 with no adjacent segment disease at L3-4. On physical examination, she had a well healed anterior incision equal and symmetric and biceps brachial radialis triceps reflexes and no sensory loss and on examination of the low back she had a well healed midline incision with mild paravertebral muscle spasm and positive sciatic notch tenderness bilaterally and she was reported to have paresthesias in the S1 nerve root distribution bilaterally and the L3 and L4 nerve root distribution on the left and the right with anterior thigh weakness and weakness of the quadriceps on the left. She was subsequently recommended to undergo a gadolinium enhanced MRI of the lumbar spine.

The initial review was performed on 11/01/12 by Dr.. The request as reviewed by Dr. was for MRI of the cervical spine which was not supported as medically necessary. Dr. found that the clinical documentation provided for review did not support updated MRI studies. He noted that the most recent exam findings revealed no new neurological deficits on exam and the radiographs of the cervical spine reported stable neurological findings. He further noted that, due to the retained hardware in the cervical spine, MRI studies would be limited due to metallic artifact.

On 12/10/12, the request for MRI of the lumbar spine was reviewed by Dr.. Dr. non-certified the request, noting or citing the previous review by Dr. who recommended that the patient undergo CT myelogram due to the retained hardware in the cervical spine and noted that the patient had implanted hardware in the lumbar spine and MRI would be of limited diagnostic value as post other diagnostic testing, including CT myelogram, and he subsequently found the request for MRI of the lumbar spine as non-certified.

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

The request for MRI of the lumbar spine is not supported as medically necessary and the prior utilization review determinations are upheld. The available clinical records indicate that the claimant sustained an injury to her low back which has resulted in multiple fusion procedures or multiple surgical procedures. It would appear from the notes as submitted by Dr. that the claimant has evidence of pseudoarthrosis at the prior surgical levels. Further, the claimant is noted to have retained hardware at L4 and L5 and S1. Significant artifact will result with the use of MRI and these studies will be essentially non-diagnostic. Further, given there is a reference to possible pseudoarthrosis at the prior surgical levels, CT would be indicated to evaluate the residual bone stock. Therefore, noting the lack of instability, lack of independent radiograph study, lack of evidence of a progressive neurological deficit, and

noting that there is significant retained hardware in the lumbar spine, the requested MRI of the lumbar spine would not be supported as medically necessary under the Official Disability Guidelines.

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)