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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Dec/09/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: lumbar MRI w/without contrast

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] 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. It is the opinion of this reviewer that the request for lumbar MRI w/without contrast is not medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male although the date of birth is in question. He has undergone a previous L5-S1 decompression and fusion in 1992. No more spine x-rays demonstrated preservation of the L4-5 disc space with a right-sided instrumented fusion and bilateral L5-S1 bone bridge fusion with mild sclerosis of the SI joints worse on the right. He was neurologically intact. The records indicate that he was seen on 06/25/10 for his low back pain, and an MRI was recommended at that time. A MRI was ordered to assess spinal stenosis adjacent to his previous fusion.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On 11/07/14, a request was made for utilization review determination with a final report being made on 11/10/14 it was noted then that in order for this patient to be a candidate for this study there must be a thorough detailed history which can be correlated with a thorough exam such that a history and exam can be corroborated by the films. That was not the case at that time and there was no detailed regarding the distribution of the pain, the exact location or the pattern or the frequency or severity of the pain or quality of pain. Therefore, there is a submission of documentation that the flare up was significant to warrant an MRI. On 11/10/14, a request for utilization review determination with the final report being made on 11/17/14. It was noted the documentation did not provide specifics to indicate the presence of any new changes on neurological exam compared to previous to support the medical necessity of the requested diagnostic study.

The provider indicates he wants to obtain this MRI to assess adjacent level stenosis. The previous determinations utilized Official Disability Guidelines in making a determination. Those guidelines indicate that MRI may be considered reasonable for uncomplicated low back pain with prior lumbar surgery. The last clinical exam noted the patient was demonstrating evidence of radicular type symptoms right worse than left and he had pain with ambulation and extension with his legs with subjective weakness. It was also noted since he

was not improving an MRI with contrast to evaluate for lumbar spinal stenosis was recommended since he was demonstrating signs and symptoms of neurogenic claudication. He had subjective complaints of weakness when walking too far and when he sneezed or coughed his pain went shooting down both of his legs but he denied bowel or bladder dysfunction. The issues raised on initial determinations have not been resolved and therefore recommendation is for non-certification of this request with upholding the previous determinations. It is the opinion of this reviewer that the request for lumbar MRI w/without contrast is not medically necessary and the prior denials are 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)