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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:
Jan/03/2014

IRO CASE #:

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

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Orthopedic Surgery

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Peer review dated 04/23/13
Clinical note dated xx/xx/xx
X-rays of the lumbar spine dated 11/12/12
Clinical note dated 11/19/12
Clinical note dated 12/03/12
Clinical note dated 12/24/12
MRI of the lumbar spine dated 12/17/12
Clinical note dated 01/07/13
Clinical note dated 01/14/13
Clinical note dated 02/25/13
Clinical note dated 03/25/13
Clinical note dated 04/15/13
Clinical note dated 04/29/13
Clinical note dated 05/09/13
Clinical note dated 05/13/13
Behavioral evaluation dated 10/31/13
Clinical note dated 06/04/13
Clinical note dated 06/10/13
Clinical note dated 07/03/13
Clinical note dated 07/10/13
Clinical note dated 07/22/13
Clinical note dated 08/26/13
Clinical note dated 09/09/13

Clinical note dated 09/16/13
Clinical note dated 10/21/13
Clinical note dated 10/30/13
Clinical note dated 11/11/13
Clinical note dated 11/26/13
Clinical note dated 12/16/13
Adverse determinations dated 10/28/13 & 12/02/13

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male who reported an injury regarding his low back when he slipped on some ice and landed flat on his back. The clinical note dated xx/xx/xx indicates the patient having presented to the emergency room following the initial incident and was treated with pain medications and muscle relaxants. The note mentions the patient continuing with discomfort. The note does mention the patient having a significant past medical history involving a herniated disc in the low back. The patient rated his low back pain as 5/10 with radiation of pain to both buttocks, the posterior thighs, and the anterior thighs. The patient also described a pins and needles sensation with numbness. The x-rays of the lumbar spine dated 11/12/12 revealed mild disc narrowing at L5-S1. The MRI of the lumbar spine dated 12/17/12 revealed advanced degenerative findings at L5-S1. A right paracentral disc protrusion mildly narrowing the right lateral recess was further noted. Mild to moderate right foraminal stenosis was further noted. Degenerative findings were further noted at L4-5 with mild narrowing of the left foramen. A chronic Schmorl's node was noted in the L2 superior end plate. The clinical note dated 02/25/13 indicates the patient stating low back and leg symptoms had subsided. However, the patient did continue with complaints of discomfort. Tenderness was noted upon palpation at the L4-5 and L5-S1 levels as well as the right buttocks. The clinical note dated 04/29/13 indicates the patient continuing with significant pain in the low back with radiation of pain into both lower extremities, right greater than left. The note mentions the patient having been undergoing physical therapy. The patient rated the pain as 7-10/10. The note mentions the patient continuing with the use of Hydrocodone. The clinical note dated 07/10/13 mentions the patient able to demonstrate heel and toe walking. The patient was able to squat halfway with a full recovery. The patient did demonstrate decreased right lateral flexion. The clinical note dated 09/09/13 mentions the patient continuing with low back pain. The note does mention the patient having previously failed a drug test. The clinical note dated 10/21/13 indicates the patient being recommended for a 2nd MRI of the lumbar spine.

The utilization review dated 10/28/13 resulted in a denial for a repeat MRI of the lumbar spine as no information was submitted regarding the patient's significant changes in the symptomology. No information was submitted regarding the patient's physical examination revealing any neurocompression or recurrent disc herniation.

The utilization review dated 12/02/13 resulted in a denial for an MRI of the lumbar spine as no information was submitted confirming a functional loss in a myotomal pattern in the lower extremities.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The documentation submitted for review elaborates the patient complaining of low back pain with radiation of pain into the lower extremities. An MRI of the lumbar spine is noted to have been completed in December of 2012. A repeat MRI would be indicated provided the patient meets specific criteria to include significant changes noted in the patient's clinical presentation or significant pathology noted by provocative testing. No information was submitted confirming the patient's significant changes in the symptomology. Additionally, no information was submitted regarding the patient's significant pathology that would warrant the medical need for a 2nd MRI. As such, it is the opinion of this reviewer that the request for an MRI of the lumbar spine without contrast is not recommended as medically necessary.

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)