



Notice of Independent Review Decision - WC

DATE OF REVIEW:

12/11/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI of the Lumbar Spine without Contrast – CPT Code 72148

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

Board Certified in Physical Medicine and Rehabilitation

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 or not medical necessity exists for each of the health care services in dispute.

MRI of the lumbar spine without contrast – CPT code 72148 - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Lumbar MRI, Imaging, 10/27/11
- Office Visit, 08/01/13, 08/15/13, 09/05/13, 09/19/13, 10/10/13, 11/11/13
- DWC Form 73, 08/01/13, 08/15/13, 09/05/13, 09/19/13, 10/10/13, 11/11/13
- Physical Therapy Initial Evaluation, 08/20/13
- Physical Therapy Re-Evaluation, 09/17/13
- Denial Letters, 09/09/13, 11/01/13, 11/14/13, 11/18/13
- Pre-Authorization, 10/11/13
- Outpatient Consultation Encounter, 10/17/13

- Physical Therapy Discharge, 10/22/13

PATIENT CLINICAL HISTORY [SUMMARY]:

A lumbar MRI performed in October 2011 showed a defect in the right sided posterior elements of L4 vertebra, likely post-surgical. There were posterior annular tears in L3-L4, L4-L5, and L5-S1 intervertebral discs. At L2-L3, there was mild diffuse disc herniation by approximately 1.5 mm causing no significant narrowing of the spinal canal. At L3-L4, there was diffuse disc herniation by approximately 3 mm, causing mild indentation on the ventral aspect of the thecal sac. At L4-L5, there was diffuse disc herniation by approximately 1.5 mm with a focal central sub-ligamentous disc extrusion, measuring approximately 6.5 mm in size. At L5-S1, there was posterior disc herniation by approximately 4 mm with bilateral facet arthropathy, causing mild narrowing of spinal canal and bilateral neural foramina. The patient was injured on xx/xx/xx when he stepped wrong and lost his footing, causing his heel to hit the ground, causing low back pain. The initial diagnoses were lumbago, sprain lumbosacral, and spasm of muscle. Medications included Naprosyn and Ultracet. A Medrol dosepak and Zanaflex were added. Physical therapy was recommended and started. The patient was later referred for pain management evaluation, as well as for a lumbar MRI. The pain management evaluation indicated the claimant had bilateral low back pain secondary to probable worsening of disc herniation or annular tear at L4-L5 and a new MRI of the lumbar spine was recommended.

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

In my medical opinion, the lumbar MRI scan requested is not medically reasonable and necessary. The Official Disability Guidelines clearly require a failure of conservative treatment and objective evidence of lumbar radiculopathy prior to consideration of advanced imaging. This criteria is not met in the documentation provided and the lumbar MRI scan, therefore, does not appear to be medically reasonable or necessary.

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

- DWC - DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**