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**Notice of Independent Review Decision**

**DATE OF REVIEW:** March 21, 2014

**IRO CASE #:**

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

MRI with and without contrast with IV protocol of lumbar spine.

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

M.D., Board Certified in Orthopedic Surgery.

**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)

The requested MRI with and without contrast with IV protocol of lumbar spine is medically necessary.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who reported a work-related injury on xx/xx/xx. This patient had surgery on 10/11/13 with a preoperative diagnosis of severe foraminal stenosis at L4-5 and L5-S1 secondary to disc protrusion at L4-5 and L5-S1 with disc herniations at both L4-5 and L5-S1. The procedure performed included a radical discectomy at L4-5 and L5-S1 with partial corpectomy on the inferior aspect of L4 and superior aspect of L5 at the L4-5 segment. There was placement of a prosthetic spacer at the L4-5 level and there was a full radical discectomy at

L5-S1 with a partial corpectomy at the inferior aspect of L5 and superior aspect of S1 and placement of full radical discectomy and interbody fusion at L5-S1 with prosthetic cage at L5-S1 with screws in the vertebral body of S1. X-rays obtained on 11/4/13 indicated this patient had undergone a posterior lumbar fusion across L4 and S1 with grafts at both L4-5 and L5-S1 with the remainder of the lumbar spine unchanged when compared to previous exam and there was some degenerative changes at L1-2 above the graft where there was almost complete loss of disc space height. There was also no anterior or retrolisthesis. On an office visit dated 12/20/13 the patient reported he was having more left leg complaints and was taking Lyrica but did not get a refill. X-rays at that time showed good placement of the interbody fusion grafts and posterior pedicle screws with no change in the intraoperative alignment. He restarted the Lyrica at that time. He previously had x-rays which did not show any implant displacement. He had repeat x-rays on 1/17/14 which showed fairly appropriate alignment of the screws and hardware but he was still having complaints of radicular pain that had not improved. He also reported a hard fall on the ice on the left after reconstruction and he had significant left leg pain since that time. He was slow to walk and had positive radicular complaints but there was no new neurological deficits appreciated. The patient's provider recommended an MRI.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Per the denial letter dated 2/4/14, the URA indicated that the patient was noted to not have enough conservative treatment prior to considering the repeat MRI after the patient's recent fall.

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

Official Disability Guidelines indicate that a magnetic resonance imaging (MRI) may be considered reasonable if there is lumbar spine trauma with neurological deficits and if there is uncomplicated low back pain with radiculopathy after at least one month of conservative care or sooner if severe or progressive neurological deficits exists or if there is low back pain after prior lumbar surgery. In this case, the patient has had trauma to the back with a fall and has radicular pain. In addition, this patient is status post lumbar fusion from L4 to S1 with continued radicular pain and has had a fall. X-rays do not show any hardware complications at this point. Finally, the patient has had previous lumbar spine fusion and the MRI will help determine if there are any deficits that the x-ray has not shown. Therefore, this request is considered medically necessary at this time.

In accordance with the above, I have determined that the requested MRI with and without contrast with IV protocol of lumbar spine is medically necessary for treatment of the patient's medical condition.

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

- ACOEM- AMERICAN 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 JUDGMENT, 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)**