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Notice of Independent Review Decision

DATE OF REVIEW: 1/05/2015

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar MRI without contrast.

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

M.D. Board Certified in Occupational Medicine and Urgent Care.

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)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient has filed a claim for chronic low back pain reportedly associated with an industrial injury. The date of injury has not been furnished by the attending provider or the claims administrator.

Thus far, the applicant has been treated with the following: Analgesic medications; earlier lumbar fusion surgery; transfer of care to and from various providers in various specialties; unspecified amounts of physical therapy; and earlier lumbar MRI imaging of September 13, 2012, notable for a previous osseous fusion of the L3-L5 level with moderate broad-based disk bulging and hypertrophic changes noted at the L2-L3 level.

In a November 11, 2014 progress note, the applicant reported persistent complaints of low back pain, reportedly unchanged, it was stated in one section of the note. The applicant's medication list included Zipsor, Naprosyn, Arthrotec, Coumadin, Prilosec, Zestoretic, Tenormin, zinc, magnesium, and Mobic. It was not clear when the applicant's medication list had last been updated, as the documentation provided suggested that the applicant was using multiple NSAIDs in conjunction with Coumadin. The applicant was status post a left knee total knee arthroplasty, an aortic valve replacement, and left and right carpal tunnel release surgery. The applicant was obese, with a BMI of 33. The attending provider stated that the applicant's spine surgery had been denied. The attending provider stated that he was requesting updated MRI imaging, presumably as a prerequisite to pursue a spine surgery. Chiropractic manipulative therapy was sought. Zipsor was refilled. The applicant's work status was not clearly outlined.

In an August 14, 2014 progress note, the applicant presented with complaints of low back pain radiating to the bilateral lower extremities, persistent and worsening. The applicant stated that he was very limited in terms of what he could and could not do secondary to pain complaints. X-rays of the lumbar spine were performed, demonstrating instability above the previous lumbar fusion. The applicant reportedly exhibited evidence of a fusion at L4-L5 and L5-S1 with instability, anterolisthesis, and asymmetric disk



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collapse at L3-L4, causing impingement upon the exiting nerve roots. A lumbar fusion surgery was proposed.

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

Per ODG references the requested "Lumbar MRI without contrast" is medically necessary. As noted in ODG's Low Back Chapter MRI Imaging topic, MRI imaging is the "test of choice" for applicants who have had prior back surgery. This patient has undergone reportedly unsuccessful multilevel lumbar fusion surgery. The requesting provider's documents state the applicant's low back pain and associated radicular complaints are progressively worsening with time and that the applicant is a candidate for revision lumbar fusion surgery and/or extension of the fusion surgery to an adjacent level. X-ray imaging of the lumbar spine apparently demonstrated evidence of disk collapse, adjacent segment disease, and nerve root impingement. Obtaining MRI imaging for preoperative planning purposes, as a precursor to pursuit of planned lumbar fusion surgery, is indicated. Therefore, the request is medically necessary.

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

- 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