

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 31, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Lumbar MRI without contrast (72148)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
724.2	72148		Prosp	1			Xx/xx/xx	xxxxx	Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee is a female who reported sustaining an injury in xxxx resulting in a lumbar spinal fusion.

The more recent records provided began with a prior lumbar spine CT scan provided from June 12, 2014, documenting:

1. A loss of lumbar lordosis without evidence of fracture,
2. A prior extensive laminectomy was noted, consisting of changes with fusion from L1 through L4,
3. An anterior body fusion at L3-L4 and L4-L5, and
4. A disc protrusion on the left at L5-S1.

Thoracic and lumbar spine x-rays were performed October 6, 2014, documenting diffuse degenerative changes without evidence of acute fracture or dislocation.

A progress note from October 15, 2014, noted back pain from a prior injury in xxxx and was status post-surgery without recent treatment. Reports of low back pain with radiation down the bilateral legs were documented. The physical examination findings documented equal and intact lower extremity reflexes. Normal gait and normal sensation were documented. Physical therapy was recommended at that time.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDELINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division-mandated Official Disability Guidelines the request for an MRI of the lumbar spine would not be warranted at this time. The prior non-authorization for a repeat MRI of the lumbar spine from December 5, 2014, would be supported. The physical examination findings noted most recently in October of 2014 documented no evidence of a neurological deficit. Prior diagnostic imaging from June of 2014 documented prior postsurgical changes without evidence of a recurrent spinal stenosis. Without substantial changes in the physical examination findings, recent trauma, or documentation of progressive neurological deficit; the request for a repeat MRI would not be warranted at this time.

ODG -TWC

ODG Treatment

Integrated Treatment/Disability Duration Guidelines

**Low Back - Lumbar & Thoracic (Acute & Chronic)
Back to ODG - TWC Index (Updated November 21, 2014)**

Imaging would only be indicated if there were severe progressive neurologic impairments, signs or symptoms indicating a serious or specific underlying condition, or if the individual is a candidate for invasive interventions. Immediate imaging is recommended for individuals with major risk factors for cancer, spinal infection, cauda equina syndrome, or severe or progressive neurologic deficits. Imaging after a trial of treatment is recommended for individuals who have minor risk factors for cancer, inflammatory back disease, vertebral compression fracture, radiculopathy, or symptomatic spinal stenosis. Subsequent imaging should be based on new symptoms or changes in current symptoms. (Chou, 2011).

Indications for imaging -- Magnetic resonance imaging:

- Thoracic spine trauma: with neurological deficit
- Lumbar spine trauma: trauma, neurological deficit
- Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit)
- Uncomplicated low back pain, suspicion of cancer, infection, other "red flags"
- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit.
- Uncomplicated low back pain, prior lumbar surgery
- Uncomplicated low back pain, cauda equina syndrome
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, painful
- Myelopathy, sudden onset
- Myelopathy, stepwise progressive
- Myelopathy, slowly progressive
- Myelopathy, infectious disease patient
- Myelopathy, oncology patient

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
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)