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IRO Cert#XX

DATE OF REVIEW: AUGUST 13, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Repeat MRI Lumbar Spine 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:

XX Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a XXXX who was injured on XXXX, in a mechanism that was not denoted. The claimant was diagnosed with spondylosis without myelopathy or radiculopathy in the lumbosacral region. An evaluation on XXXX, documented complaints of low back and bilateral lower extremity pain. There were previous facet joint injections with temporary relief. An L5-S1 artificial disc replacement was performed in XXXX. The surgical scars were well-healed. There was a normal gait. The paravertebral muscles were tender on the left. Lumbar range of motion was painful and restricted in flexion. Straight leg raise testing was normal. Lower extremity strength was symmetric in all groups. The lower extremity reflexes were present and normal. A bilateral L5-S1 facet joint injection was performed on XXXX. Medications included XXXX. An MRI on XXXX, documented an artificial disc arthroplasty at L5-S1. There was susceptibility artifact inhibiting interpretation of the neural foramina. There was no obvious disc herniation, central canal stenosis, high-grade foraminal stenosis, or nerve root compression. Cephalad to the total disc arthroplasty was degenerative retrolisthesis of L2 on L3. There was pseudodisc of listhesis with underlying endplate spondylosis and mild narrowing of the neural foramen and abutment of the descending L3 nerve roots bilaterally. Degenerative retrolisthesis of L3 on L4 was noted with pseudodisc of listhesis underlying endplate spondylosis and facet arthropathy which mildly narrowed the neural foramen and abutment of the L4 nerve roots bilaterally. Concentric disc displacement was noted of L5-S1 along with facet arthropathy resulting in mild left and moderate right neural foraminal narrowing and abutment of the exiting right L4 nerve root. There was noncompressive disc displacement of L1-L2 and noncompressive shallow broad-based displacement of T11-T12.

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/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

The previous non-certification on XXXX, was due to lack of guideline support, lack of previous diagnostic injections, and the physical examination findings. Repeat MRI studies are not

routinely recommended and should be reserved for significant changes in symptoms or findings suggestive of significant pathology. Additional records were not submitted for review. The previous non-certification is supported. The records do not reflect recent traumatic injury to warrant a repeat MRI. The physical examination had normal neurological findings. The records do not reflect any significant or progressive changes in the lumbar or lower extremity regions. The medical necessity for a repeat MRI to the lumbar spine without contrast has not been established and therefore not certified.

Official Disability Guidelines Low Back (updated 7/6/2018) Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation)

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

☐ AHRQ- 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

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)