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Date notice sent to all parties: 06/11/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar MRI

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified in Orthopedic Surgery

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

☐ Overturned (Disagree)

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

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.
Lumbar MRI – Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:
A lumbar MRI dated XXXX revealed severe right and moderate left neural foraminal stenosis at L5-S1. There was moderate right greater than left neural foraminal stenosis at L4-L5 with a midline annular tear at this level. A disc extrusion was noted with superior extrusion at T12-L1 at the midline. XXXX examined the patient on XXXX for XXXX date of injury. XXXX had received a lumbar ESI with temporary relief. XXXX had bilateral leg electrical pain, numbness, and tingling since the date of injury, greater on the right than the left. XXXX had pain with range of motion. Strength was 5/5 in the lower extremities. Patellar reflexes were 2, the Achilles was 2 on the right and 1 on the left, and the posterior tibialis reflexes were absent bilaterally. Straight leg raising was negative and there was no sensory deficit documented. The assessment was a lumbar sprain/strain. XX, XX, and XX were continued and a new lumbar MRI was recommended. The Benefit Dispute Agreement dated XXXX was reviewed. On XXXX, a preauthorization request was submitted for a lumbar MRI, which XXXX, provided a non-authorization for on XXXX. XXXX provided letters to XXXX regarding the denial on XXXX. The patient followed-up with XXXX on XXXX. There were now no reflexes at the posterior tibialis or Achilles' bilaterally. Sensation was decreased on the right at L4. Straight leg raising was positive on the right. It was noted the MRI had been denied and the findings of the XXXX MRI were reviewed. It was noted progressive more neurological changes kept taking place and they would request a reconsideration request. XXXX office submitted another preauthorization request on XXXX for a lumbar MRI, which XXXX, provided a denial for on XXXX. The carrier addressed another letter regarding the denial to XXXX. XXXX reexamined the patient on XXXX. They noted they had received the second denial for the MRI. On exam, strength was 5/5 in the lower extremities and now straight leg raising was positive on the right, but negative on the left. Reflexes were now absent

bilaterally at the posterior tibialis and the Achilles', but the patellar reflexes were 2 bilaterally. There was noted to be hypoesthesia at L4 on the right only. XXXX noted they would request an IRO regarding the denial of the lumbar MRI.

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

The patient is a XXXX who sustained a work-related injury on XXXX. Previous MRI scan obtained on XXXX revealed severe right and moderate left neural foraminal stenosis at L5-S1, moderate right greater than left neural foraminal stenosis at L4-L5 with a midline annular tear, and disc extrusion with superior extension at T12-L1. It would appear that the patient more recently has begun treatment with XXXX who has recommended repeat MRI imaging after XXXX initial evaluation on XXXX. XXXX request was non-certified on initial review by XXXX on XXXX. XXXX non-certification was upheld on reconsideration/appeal by XXXX. Both reviewers attempted peer-to-peer without success and both reviewers cited the evidence based Official Disability Guidelines (ODG) as the basis of their opinions. The patient was seen again on XXXX and the bulk of these evaluations are basically cut-and-paste from the initial evaluation of XXXX. The medical documentation reviewed does not show any substantial objective physical findings or significant clinical neurological changes from the patient's longstanding lumbar complaints. The ODG recommendation for repeat MRI scan notes it is not routinely recommended and should be reserved for significant change in symptoms and/or findings suggestive of significant pathology such as a tumor, infection, fracture, neural compression, or recurrent disc herniation. (Bigos 1999, Mullin 2000, ACR 2000, AAN 1994, Aetna 2004, Airaksinen 2006, and Chou 2007.) Therefore, the requested lumbar MRI scan is not medically necessary, reasonably related, or supported by the evidence based ODG and the previous adverse determinations should be upheld at this time.

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**
- X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- X **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)**