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An Independent Review Organization
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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
MRI of the lumbar spine without contrast

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

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

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:
This case involves a XXXX year-old XXXX with history of an occupational claim from XXXX. The mechanism of injury was detailed as a XXXX. The MRI of the lumbar spine from XXXX revealed L1-5 left laminectomy defect with a sizable recurrent/residual central disc protrusion. L5-S1 shows a central disc protrusion with enhancing annular fissure. The clinical note from XXXX notes that the patient complained of low back pain on the left. Pain was an 8/10 and was constant. On examination, there was left L5 and S1 dermatomes were decreased with sensation. There was tenderness to palpation noted to lumbar spine. Deep tendon reflexes were decreased at the patella on the left at 1+. Lumbar range of motion was decreased. Strength was decreased at the hamstrings at 4/5 on the left and at the quadriceps at the L2-L4 on 4/5 on the left. There was a positive braggart's test, Kemps test and milligrams test. There was a positive straight leg raise test.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The official disability guidelines note that repeat MRI is recommended when there is a significant change in symptoms and/or findings suggestive of significant pathology. The documentation indicates that the patient had completed conservative treatment. The patient had continued complaints of pain. However, there was no indication of any significant change in symptoms and/or findings suggestive of a significant pathology to warrant a repeat MRI.

As such, the request for MRI of the lumbar spine without contrast is not medically necessary and the prior determination is upheld.

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

☒ 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

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Low back, MRI (magnetic resonance imaging)