

Parker Healthcare Management Organization, Inc.

4030 N. Beltline Rd Irving, TX 75038
972.906.0603 972.255.9712 (fax)

DATE OF REVIEW: APRIL 12, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of a Lumbar MRI with contrast

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 orthopedic surgery 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)
- XX 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
unk	MRI Lumbar Spine w/contrast		Prosp	1					Overturn

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO

Respondent records- a total of 133 pages of records received to include but not limited to:

Letter from 3.28.07; Letter 2.21.07, 2.27.07; Medical records, Dr. 5.16.05-2.9.07 ; Records, Medical Center, 5.24.05-6.22.06; MRI Lumbar Spine, 2.15.06; Report, ESI, 3.10.06; Elite

Physician's report, 3.21.06, 3.24.06, 4.3.06, 5.11.06; Letter from patient 4.3.06; Report, Dr. 9.28.06; FCE 9.28.06

Requestor records- a total of 15 pages of records received to include but not limited to: Medical records, Dr. 8.28.06-2.9.07; Records, Regional Medical Center, 6.9.06; MRI Lumbar Spine, 2.15.06

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient sustained a work related on the job. This patient's status is post a two level lumbar fusion on 6.9.06 and has recurrent symptoms.

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.

Dr. has proposed a repeat lumbar MRI with gadolinium. Reassessment of spinal canal would be reasonable and necessary given the history of care despite the lack of a progressive neurologic deficit. Thus, the denial of the request should be overturned.

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 KNOWLEDGBASE
- 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
- 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

- XX PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE** (*Spine 2 Orthopedic Knowledge Update, American Academy of Orthopedic Surgeons*)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**