

**IRO REVIEWER REPORT - WC**

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**DATE OF REVIEW:** 04-03-07

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Preauthorization for a repeat Lumbar MRI

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

Certified by the American Board of Neurological Surgery  
General Certificate in Neurological Surgery

**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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Injury Date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld Overturn
		Prospective	724.2	72148	Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Independent Review Organization Summary dated 03-23-07  
Adverse Determination Reports (Denied) dated 02-26-07 and 03-12-07  
Notice of Disputed Issues and Refusal to Pay Benefits dated 12-20-06

## **IRO NOTICE OF DECISION – WC**

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and 01-05-07

Job Description Revised October 2004

Texas Workers' Compensation Work Status Reports 04-06-05 to 03-05-07

Initial Consult/New patient Documentation Tool dated 08-01-05 Operative Report dated 11-23-05

Benefit Review Conference Report dated 08-23-06

Physician Progress Reports (transcriptions) dated 04-11-05 to 02-09-06

Physician Office Visits dated 04-18-06 to 03-05-07

Daily Note dated 05-03-05 and 05-09-06

Physician RME report of 03-31-06

Required Medical Evaluation of 07-13-06 and Addendum RME of 07-13-06

History and Physical Note dated 10-10-06

TWCC Designated Doctor Report dated 10-16-06

Office Note-Recurring Patient 12-01-05 and 10-24-05

Synopsis of Investigation 01-08-07 to 01-12-07

TDI-DWC Designated Doctor Evaluation dated 02-22-07

Dictated Physician History and Physical reports dated 02-12-07 and 02-27-07

Dictated Medical Conference Note of 03-09-07

MRI of the Lumbar Spine and Lower Thoracic Spine dated 06-15-05

MRI of the Thoracic Spine Without Contrast dated 08-02-06

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This claimant injured self at work lifting a 50lb bag of pet food. She started to have low back pain. MRI scan done on 06-15-06 revealed disc desiccation at L5-S1. She continued to complain of pain in the low back and left leg in spite of conservative treatment. The treating physician requested a repeat lumbar MRI.

### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

There is no indication for repeat Lumbar MRI. None of the treating and evaluating physicians questioned the quality of the MRI until 02-12-07. If there were any such questions, the physicians would certainly have earlier raised it. The extensive physician evaluation performed on 02-22-07 did not complain about the quality of the MRI. The EMG/NCS studies were normal and the neurological findings over the almost two years have been impressive and stable with no indication of a red flag. In addition, the findings of the 02/22/07 evaluation argue against any further studies.

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