

# Independent Resolutions Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: 817-274-0868

Fax: 817-549-0311

**DATE OF REVIEW:** JULY 10, 2007

**IRO CASE #:**

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

Repeat lumbar MRI

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

Board Certified

**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.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Office note, Dr., 05/10/07

Peer review, Dr., 06/06/07

Peer review, Dr., 06/15/07

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male injured on xx/xx/xx when he was pulling a bakery rack and developed low back pain. He was treated with chiropractic and epidural steroid injections were given in 2003 without benefit. On 05/10/07 Dr. evaluated the claimant for increased pain for one month. He also had right leg numbness in the right toe and posterolateral calf. Pain was worse with coughing, sneezing and straining. The claimant also reported occasional nocturnal incontinence. Medications were Hydrocodone and ibuprofen. On examination the claimant was able to toe and heel walk and there was no weakness with repetition. There was right leg paresthesia and back pain with slump test. There was hypoesthesia to pinprick in the right L5 and S1 dermatomes. Reflexes were intact and symmetrical. It was noted that the claimant had an MRI in 2002 that showed L40-5 desiccation and posterior herniation and L5-S1 marked narrowing of the disc space height. A repeat MRI was requested as it was felt studies were outdated. It has been denied twice and a dispute resolution apparently has been requested.

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

Repeat MRI lumbar spine appears to be medically reasonable and necessary in this male who has greater than month history of lower back pain which radiates down his right leg and is exacerbated with Val Salva type maneuvers. He is noted to have occasional nocturnal incontinence. He has been treated with Hydrocodone, ibuprofen. Clinical examination demonstrates tension signs, decreased sensation in the L5 and S1 right dermatomes. In addition to this, this patient had a 50 pounds weight loss which could quite represent a neoplasm. Based upon this information, the Reviewers medical assessment is that it's medically necessary to repeat the MRI of his lumbar spine.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Low Back Uncomplicated low back pain, suspicion of cancer, infection

- Uncomplicated low back pain, with radiculopathy, after at least month conservative therapy, sooner if severe or progressive neurologic deficit. (For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.) (Andersson, 2000)
- Uncomplicated low back pain, prior lumbar surgery
- Uncomplicated low back pain, cauda equina syndrome
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, painful
- Myelopathy, sudden onset
- Myelopathy, stepwise progressive
- Myelopathy, slowly progressive
- Myelopathy, infectious disease patient

**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)