

DATE OF REVIEW: 6/21/07**IRO CASE #:****DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Outpatient MRI without contrast.

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

This case was reviewed by a board certified orthopedic surgeon on the external review panel who is familiar with the condition and treatment options at issue in this appeal.

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)

<i>Primary Dx Code</i>	<i>HCPCS /NDC</i>	<i>Mod</i>	<i>Units</i>	<i>Type Review</i>	<i>DOS</i>	<i>Amt Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Uphold / Overturned</i>
724.2				Prospective					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for Independent Review by an Independent Review Organization forms – 6/7/07.
2. Determination Notices – 8/14/06, 8/29/06, 5/16/07, 5/29/07.
3. Records and Correspondence from Institute – 10/2/06-5/9/07.
4. Records and Correspondence from Care – 8/8/06.
5. Progress Notes - 1/25/06-8/22/06.
6. Records and Correspondence from MD – 8/22/06.

PATIENT CLINICAL HISTORY:

This case concerns an adult male who sustained a work related injury. Records provide no details regarding the circumstances of the injury. Diagnoses have included lumbago, radiculitis, failed back surgery syndrome and acute back pain. Evaluation and treatment for this injury has included surgery and medications.

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

This patient sustained a work related injury to his back. He underwent surgery years ago. He also had an MRI following surgery that did not demonstrate significant pathology. The records do not demonstrate a progressive neurological deficit. Therefore, an MRI is not medically necessary for diagnosis and treatment of the patient's condition 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
- 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)

Resnick R, et al. Guidelines for the management of low back pain. J Neurosurg Spine. 2006.