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DATE OF REVIEW: 06-03-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Magnetic Resonance Imaging Spinal Canal and Contents

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 Number	Review Type	Begin Date	ICD-9/DSMV	HCPCS/NDC	Units	Upheld/Overturned
		Prospective	05/14/07	724.02	72158	1	Upheld
		Prospective	05/14/07	724.02	72156	1	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

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Review Determinations Dated 5-3-07 and 5-14-07
Physician Evaluations of 3-16-07, 3-19-07, and 4-9-07
Physician Letter Dated 4-18-07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is status post rollover accident and continues to have “quite a bit of difficulty” turning his neck side to side with subsequent increase of posterior neck pain. Also, has low back pain radiating into both hips but sparing his legs. No complaints of paresthesiae or weakness was noted. An additional rear end auto accident occurred. Prior treatment included pain medication (Norco, then Lortab), Flexeril, pain management, steroid injections, and physical therapy.

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

The requested procedure of Magnetic Resonance Imaging Spinal Canal and Contents is not medically necessary. According to the documentation provided, the claimant’s neuro exam was within normal limits, but does not address motor function; deep tendon reflexes (DTRs) were noted to be hyperactive but plantar responses were normal. The claimant has had physical therapy and is working. There is no evidence of change or deterioration in neurological status.

Reference:

ACOEM, Ed ii, 2004 Chapters 8 and 12.

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**

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- 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)**