

P-IRO Inc.

An Independent Review Organization

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DATE OF REVIEW:

MARCH 21, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat MRI of the lumbar without contrast

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

Board Certified Orthopedic Surgeon

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

X-rays lumbar spine 06/07/2005

MRI lumbar spine 07/13/05

Office note of Dr. 11/27/06

Prescription 01/02/04

Office note of Dr. 01/02/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This Patient sustained a back injury. The records indicated that the Patient has had persistent lower back pain since the injury. An MRI of the lumbar spine done

on 07/13/05 showed mild to moderate L5- S1 stenosis secondary to a partial collapse of the disc with associated diffuse disc bulge and facet hypertrophy. There was mild L4-5 foraminal narrowing secondary to a diffuse disc bulge and facet hypertrophy. The Patient treated conservatively with medications, physical therapy and work modifications without benefit.

A consultation done on 01/02/07 revealed the Patient with pain in the lower back and occasional numbness across the anterior thigh. There was lumbar tenderness and spasm on examination. The motor and sensory examination was intact with no focal dermatomal deficits. Flexion and extension x-rays taken on this visit showed a fairly significant degenerative change at L5-S1 disc that was nearly bone on bone. The Patient was diagnosed with persistent and ongoing lower back pain. The physician noted that the Patient had not had conservative management or diagnostic imaging in over one year. In addition to conservative care, a new MRI was recommended.

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

The repeat MRI of the lumbar spine is not recommended as medically necessary. The Patient had a previous MRI performed in July of 2005. There has not been any significant change in the Patient's clinical condition since that time and there is no evidence that a repeat MRI would change the treatment or change his clinical course in any significant way.

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)