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Notice of Independent Review Decision

DATE OF REVIEW: 08/04/08

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

Certified by The American Board of Orthopaedic 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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective			Upheld

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INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Notice dated 6/5/08
Adverse Determination After Reconsideration Notice dated 6/17/08
Letter dated 7/24/08
Medical notes dated 5/16/06, 6/12/06, 1/8/07, 5/8/08, 6/2/08, 6/8/08
ODG Low Back – Lumbar & Thoracic (Acute & Chronic)
Patient Referral Form dated 5/28/08
CT Lumbar Spine dated 8/14/06
Lumbar Myelogram dated 8/14/06
MRI Lumbar Spine dated 12/19/06
CT Lumbar Spine dated 5/2/06
Fax dated 5/29/08
Consultation note dated 7/6/06
EMG dated 7/6/06

PATIENT CLINICAL HISTORY:

This xx-year-old patient sustained a work-related back injury on xx/xx/xx. He has continued complaints of low back pain with numbness in his left leg and pain in his left hip. Multiple imaging studies have been completed, including a lumbar MRI done 12/2006, which showed a small right-sided disc herniation at L4-5. Treatment has included chiropractic, physical therapy, and medication management.

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

In the Reviewer's opinion, a repeat lumbar MRI is not medically necessary. The Reviewer noted that the Division mandated Official Disability Guidelines state "Repeat MRIs are indicated only if there has been progression of neurologic deficit." The Reviewer noted that the medical records do not show that the patient has had any progression of neurologic disorder. Therefore, in the Reviewer's opinion, there is no indication for a repeat lumbar MRI for this patient.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

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- 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)**