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Notice of Independent Review Decision

DATE OF REVIEW: 08-01-2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI lumbar spine

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	HCPCS/ NDC	Upheld/ Overturned
		Prospective	72148	Upheld

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PATIENT CLINICAL HISTORY:

The claimant is a male who sustained a lumbar sprain/strain injury on xx/xx/xx when stepping down and slipping on a step. He has a history of past lumbar spine surgery in xxxx. The patient has low back pain that radiates down his left leg, with numbness and tingling in that leg. A medical note from June 2008 notes the patient has pain that is described as “stabbing” at a level of 7/10 and radiates down his left leg. He has received physical therapy, epidural steroid injections and facet injections for the pain, 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 MRI for this patient’s xx/xx/xx injury is not medically necessary.

The Reviewer noted that the patient has a history of prior low back pain and lumbar surgery in xxxx, and a repeat MRI has been requested to further evaluate his back pain and help establish an overall treatment plan. The Reviewer commented that the MRI of xx/xx/xx, approximately one month prior to the patient’s xx/xx/xx injury, noted L5-S1 bilateral stenosis and a disc bulge. The EMG obtained in November 2006 noted no electrodiagnostic findings of acute lumbarsacral radiculopathy in the right or left lower extremities and findings of peripheral neuropathy on right and left lower extremities.

In the Reviewer’s opinion, there appears to be a clinical indication for obtaining a MRI for the xxxx date of injury, but no indication to obtain a MRI to address the sequela of the xx/xx/xx date of injury. The Reviewer noted that the standards for obtaining a MRI as outlined in the ODG are met for the preexisting disc lesion.

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

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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)**