Advanced Medical Reviews

ACCREDITED EXTERNAL REVIEW

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 12/3/2008
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
MRI of the lumbar spine with and without contrast

QUALIFICATIONS OF THE REVIEWER:
This reviewer graduated from University of Missouri-Kansas City and completed training in Physical Med & Rehab at Baylor University Medical Center. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Physical Med & Rehab since 2006 and Pain Management since 2006.

REVIEW OUTCOME:
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part) MRI of the lumbar spine with and without contrast.

Upheld

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:
The injured employee is a xx year old female with a history of chronic low back pain with a date of industrial injury on xx/xx/xx. She had a previous lumbar MRI study in 2005 and it was unchanged. It is also noted that the injured employee was having persistent pain in both the neck and back regions and was still working full time.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
The clinical documentation provided for review was reviewed detail. The previous denial of MRI of the lumbar spine with and without contrast is upheld. There is insufficient medical evidence to support any of the medical necessity criteria outlined in ODG regarding indication for an MRI. It is also unclear from the single office note submitted dated 10/16/08 why a contrasted MRI is necessary as well. The case history, exam, and prior treatments or work up are all lacking in the documentation. Therefore, as medical necessity is not established, the previous denial is upheld.

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
X 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)