

Notice of Independent Review Decision

DATE OF REVIEW: 03-17-08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI of Lumbar Spine

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

Certification by the American Board of Physical Medicine and Rehabilitation

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	804.9	72148	Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notices of Preauthorization Denial and Rationale, dated 02-04-08 and 02-15-08
 Medical notes, dated 09-21-07, 11-01-07, 11-08-07, 11-09-07, 01-10-08, 02-18-08
 (with addendum dated 02/27/08)
 Laboratory report, dated 09-21-07
 Peer review report, dated 10-09-07
 X-ray of the lumbar spine, dated 09-18-07
 MRI of the lumbar spine, dated 09-24-07
 Preauthorization information

Notice of Independent Review Decision
Page 2

Case management notes, dated 01-15-08
Official Disability Guidelines (ODG) – MRI

PATIENT CLINICAL HISTORY:

This claimant was initially evaluated in the Emergency Room when the claimant tripped and fell over a box. The follow-up evaluation on August 21, 2007, noted the transverse process fractures on x-ray, and the claimant was noted to have radicular distribution type pain. The treatment plan included MRI and continuation of medications as directed for pain.

Peer review evaluation on October 9, 2007 indicated that the facet and arthritic changes were not caused or worsened by the injury. An MRI done noted a disc herniation at the L5-S1 level and that the transverse process fractures were healing. By February 2008, it was noted that there was radiating pain in the left lower extremity and weakness in the left lower extremity. A neurosurgical evaluation was scheduled for April and a repeat MRI was suggested.

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

The Reviewer commented that there is no medical necessity when considering the data noted as of January 10, 2008, and the physical examination reported. The non-certification noted a lack of documentation of a progression of neurologic deficit. The follow-up physical examination noted lower extremity pain in radicular pattern.

However, at the time of the February 18, 2008, examination, there are reflex losses on the left, a motor loss is noted, straight leg raising is positive, and heel walking is now not achievable. These amended physical examination findings would support a repeat MRI as noted in the ODG.

Therefore, based on the requirements for a repeat MRI and that these requirements are now reported after the prior non-certification, this study is recommended at this time. It should be noted that, based on the clinical information presented at the time of the initial request and at the time of the reconsideration, the non-certification was in keeping with the ODG. It is the data presented after the date of reconsideration that places this request within the parameters established by the ODG.

**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)