



# Lumetra

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 05-30-08

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

MRI L-Spine w/o to include 72148

### **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	724.4	72148	Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Review Determination dated 04-18-08 and 05-01-08  
Physician progress reports dated 08-11-07, 08-27-07, 10-13-07, 10-22-07,  
11-19-07, 11-20-07, 12-06-07, 01-03-08, 03-24-08

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Designated Doctor Evaluation dated 12-18-07  
MRI report dated 08-23-07  
Lumbar spine series dated 09-25-07  
Neurological Consultation dated 09-25-07  
Medical office notes dated 09-26-07, 04-14-08, 04-22-08  
Official Disability Guidelines (ODG) Low Back - MRI - Indications for imaging  
Peer Review dated 04-29-08

**PATIENT CLINICAL HISTORY:**

This is a xx -year-old claimant who suffered a back injury lifting a table on xx/xx/xx. The claimant presented to the primary treating physician on August 11, 2007, complaining of low back pain with left lower extremity weakness. The claimant was noted to be borderline hypertensive and obese. Bunion pain was also noted.

At follow-up on August 27, the pain complaints were continuing, the medications were continued, and radiculopathy was reported. A surgical referral was made. No surgical consultation was included for review.

A Designated Doctor evaluation was completed. A lumbar MRI noted circumferential disc bulge and facet arthrosis in this claimant. Plain films showed "age appropriate degenerative changes in the lumbar spine." Neurological consultation noted no instability, and surgical lesion was identified. A repeat MRI was requested.

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

The Reviewer reviewed the mandated Official Disability Guidelines and determined that the requested MRI is not medically necessary. The criteria as outlined in the ODG include – Uncomplicated low back pain, with radiculopathy, after at least one month conservative therapy, sooner if severe or progressive neurological deficit. In the opinion of the Reviewer, and based on medical records submitted, there is no competent, objective, and independently confirmable medical evidence of a verifiable radiculopathy and, as such, no indication for a repeat MRI.

**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)