

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 5/13/2008
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat lumbar MRI (72148)

QUALIFICATIONS OF THE REVIEWER:

This reviewer attended Boston University before graduating from Emory School of Medicine in Atlanta, Georgia. She did her residency in neurosurgery and a fellowship in pediatric neurosurgery at the Children's National Medical Center in Washington, DC. She has had numerous publications and is an active member of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons. She is a licensed medical doctor in five states.

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)

Repeat lumbar MRI (72148) Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Case assignment dated 4/28/2008
2. Request for a review dated 4/25/2008
3. Clinical note by MD dated 4/9/2008
4. Clinical note by LVN dated 4/16/2008
5. Request for a review dated 4/24/2008
6. Clinical note dated 5/1/2008
7. Clinical note by MD dated 4/9/2008
8. Clinical note by LVN dated 4/16/2008
9. Office notes by MD dated 12/17/2003 to 3/11/2008
10. Final report by MD dated 12/12/2003
11. Disability duration guidelines dated unknown
12. Treatment history dated 5/1/2008
13. Official Disability Guidelines (ODG)

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a male with a diagnosis of thoracic or lumbosacral neuritis. His date of injury was xx/xx/xxxx while lifting. An MRI in 2003 noted a disc herniation at the L4-S1 levels. In 2003 and 2004 he was treated with physical therapy. He has not had any therapy since. He was believed to be symptomatic from a right L5 radiculopathy secondary to a right-sided L4-L5 herniated disc. There was a smaller herniated disc at L5-S1. At that time, the plan was to perform a microdiscectomy should he not improve. He presents with recurrence of pain and no changes on examination. A repeat lumbar MRI is under review.

Name: Patient_Name

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

An MRI is not medically necessary at this time. As pointed out by Insurance Company, there are no documented physical findings, nor are there documented physical complaints. After 4 years, there should be a detailed history and physical examination. The medical necessity of a repeat MRI has not been established and therefore 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
- 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)