

IRO Express Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: 09/29/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Magnetic resonance (EG proton) imaging, spinal canal and contents, without contrast material, followed by contrast material in further sequences; lumbar

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

M.D., Board Certified in Anesthesiology

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Denial Letters 8/12/08 and 8/18/08

Records from Dr. 5/16/08 thru 8/27/08

MRI 11/8/07

PBI 8/12/08 and 8/18/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient last had an MRI of the lumbar spine on 11/08/07 for symptoms of low back pain that radiates into the bilateral lower extremities. On date of service 07/29/08, a request for an MRI of the lumbar spine was made. There is no mention of this patient having previous lumbar spine surgery or change in

symptoms. There are also no neurological deficits noted in the patient's history or physical exam findings.

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

Per the Official Disability Guidelines, one of the indications for a lumbar spine MRI is not indicated unless there has been trauma, the patient has uncomplicated low back pain with suspicion of cancer or infection, or uncomplicated low back pain with radiculopathy after at least one month of conservative therapy. It is noted that this patient has a radiculopathy and has received conservative therapy including interventional procedures. However, there is no mention of any change in the patient's symptoms. Therefore, an MRI would not be indicated. The patient has no neurological deficits as noted above. In addition, the patient has never had prior lumbar surgery nor appears to be suffering from cauda equina syndrome. Because none of the indications for imaging as outlined in the Official Disability Guidelines are mentioned, an MRI of the lumbar spine is not indicated.

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 KNOWLEDGBASE
- AHCP- 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)**