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Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 04/08/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat MRI Lumbar

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

Board Certified in Orthopedic/Neurological 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Lumbar Spine MRI w/o Contrast, M.D., 08/01/08

- Initial Chart Note, M.D., 09/15/08
- Caudal Epidural Steroid Block, Dr., 09/29/08
- Chart Note, Dr., 10/10/08, 11/21/08, 12/29/08, 02/23/08, 03/03/09
- Facet Joint Steroid Block, Dr., 12/15/08
- Repeat MRI Lumbar Request, Dr., 02/25/09
- Notification of Determination, 03/03/09
- Reconsideration of Medical Determination, 03/09/09
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The claimant sustained a lower back injury on xx-xx-xx while lifting heavy boxes. He has undergone a caudal epidural injection, as well as facet blocks, at L4-5. The most recent medications prescribed include Ibuprofen, Skelaxin and Tramadol.

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

The patient has undergone an caudal epidural injection, as well as facet blocks at L4-5, but he has had only transient improvement. His predominate complaint is low back pain with a limited radicular complaint. Neurologic examination throughout his provided care has failed to reveal any evidence of a motor or sensory deficit. He has persistent straight leg raise tests throughout his serial examinations.

An MRI of the lumbar spine was initially performed on 08/01/08, revealing what appear to be age-appropriate spondylitic changes throughout the lumbar spine. There does appear to be a lateral disc protrusion at L4-5 with some foraminal narrowing; the left greater than the right.

Since his prior MRI, I do not see any evidence of a significant interval change. His predominate complaint is low back pain with no significant radicular complaint. There is no significant neurologic deficit. I would not recommend a repeat lumbar MRI based on documentation showing only positive straight leg raise tests in the absence of other more significant neurologic deficit or progression. Further MRI scanning of the lumbar spine to assess a stable low back pain in the absence of a history of malignancy, infection, or more significant spinal pathology is not being recommended at this time.

In summary, I do not see any objective medical documentation supporting the need for a follow-up MRI in this patient.

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)**