MRI

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an Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 8/7/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of a lumbar MRI.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery and has been practicing for greater than 15 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a lumbar MRI.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
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PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a female injured while working when she fell. A lumbar workup included an MRI and the patient has been treated with facet injections for facet syndrome and trochanteric bursitis with recurrent intermittent pain. Her recent treatment interval was from 10/2008 to 5/2009, having returned to work 5/2008 working 6 days per month. Her exam on 6/09/2009 reported lumbar pain, positive straight leg raising bilaterally, decreased sensation lower right thigh, and “left lower extremity weakness was observed” and “deep tendon reflexes were abnormal at the patella and ankle bilaterally”.

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

DECISION.

The reviewer states that mention of “left leg weakness” and “decreased sensation lower right thigh” is an inadequate description to be considered a progressive neurologic defect, as laterality is incompatible and nerve defect undescribed.

ODG cite - Repeat MRI’s are indicated only if there has been progression of neurologic deficit. Uncomplicated low back pain, suspicion of cancer, infection; with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit; prior lumbar surgery; cauda equina syndrome.

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)**