SENT VIA EMAIL OR FAX ON
Jun/10/2009

Applied Assessments LLC

An Independent Review Organization
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DATE OF REVIEW:
Jun/10/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Magnetic Resonance (EG,PROTON) Imaging spinal canal and contents,lumbar; without contrast material

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Neurologist with 30 years experience in clinical practice

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Denial Letters 5/7/09 and 5/12/09
Back Institute 12/20/07 thru 4/30/09
X-Ray 1/24/08
Parpon 1/24/08
CT Lumbar 1/18/08
OP Reports 3/21/08 and 10/26/07
Radiology Report 10/26/07
PBI 5/7/09 and 5/11/09
CoPE 2/18/09

PATIENT CLINICAL HISTORY SUMMARY
In xx-xx-xx, Ms. injured her low back after an awkward, heavy lift. After an anterior L4-5 fusion followed by a 365-degree fusion, she continued with some low back pain but was able to eventually return to work in approximately 1993. In 12/07 she stated she was doing the work of 3 people for a short time prior to this date but new employees were hired and was not the case now. Her major complaint is progressively worsening back pain over the last 2 years. She has not responded to anesthetic injections of the hardware. Exam does not show motor or sensory deficit deficit, but seated SLR is positive on the left. Range of motion of the lumbar spine is decreased and antalgic. An MRI in 2007 is said to show artifact from pedicle screws. A post-myelogram CT in January, 2008 showed a 3-4 mm disk protrusion toward the

left at L3-4, severe metal artifact at L4-5 but normal nerve root sleeve filling, and a normal disk at L5-S1.

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

Why has this patient's back pain worsened? It is not from the hardware as anesthetic injection of the area did not affect the pain. Is radiculopathy present? The positive straight leg raise suggests it. The normal motor and sensory exam is against this diagnosis. Is there chronic lumbar sprain initially set off by unaccustomed additional work in 2007? Has the patient continued working in spite of her pain? Has a 2-3 week period of sedentary activity been tried? Has aqua therapy been considered? Have nutrition and her abnormal sleep patterns been addressed? MRI is not the best way to answer the question of radiculopathy. The ODG does not recommend a repeat MRI in this clinical setting.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[ ] ACOEM-AMERICA 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)