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Notice of Independent Review Decision

DATE OF REVIEW: 03/30/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat lumbar MRI

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

Board Certified in Orthopedic 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.

Repeat lumbar MRI - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An Employer's First Report of Injury or Illness form dated xx/xx/xx

Evaluations with M.D. dated 10/02/06, 10/06/06, 10/12/06, 11/15/06, 12/20/06, and 02/14/07

An Associate Statement – Workers' Compensation report dated 10/02/06

A medication prescription from Dr. dated 10/02/06

A supplemental report of injury from an unknown person (signature was illegible) dated 10/05/06

Physical therapy evaluations with M.P.T. dated 10/19/06 and 01/05/07

An EMG/NCV study interpreted by an unknown provider (no name or signature was available) dated 11/15/06

A DWC-69 form from Dr. dated 02/14/07

Evaluations with M.D. dated 03/23/07, 05/09/07, 06/20/07, 08/01/07, 09/12/07, 10/24/07, 11/28/07, and 01/03/08

MRI's of the right knee and lumbar spine on 03/29/07 interpreted by M.D.

Designated Doctor Evaluations with D.O. dated 03/30/07 and 07/08/08

A physical therapy evaluation with P.T. dated 04/10/07

DWC-73 forms from Dr. dated 10/25/07 and 12/09/07

Treatment plans with D.C. dated 02/26/08, 04/02/08, 05/01/08, 06/04/08, 06/24/08, 07/21/08, 08/18/08, 09/03/08, 09/17/08, 11/05/08, 12/08/08, and 02/05/09

Evaluations with M.D. dated 02/27/08 and 03/05/08

A Physical Performance Evaluation (PPE) with Dr. dated 03/06/08

Evaluations with M.D. dated 03/24/08, 04/07/08, 05/08/08, 07/10/08, 08/11/08, 10/30/08, 12/11/08, 01/22/09, and 02/23/09

DWC-73 forms from Dr. dated 05/01/08, 05/19/08, 06/04/08, 06/24/08, 07/21/08, 08/19/08, 09/17/08, 11/05/08, 12/08/08, 02/05/09, 02/19/09, and 03/09/09

A letter of medical necessity from Dr. dated 05/08/08

DWC-73 forms from Dr. dated 05/08/08, 07/10/08, 08/11/08, 10/30/08, 12/11/08, 01/22/09, and 02/23/09

A request for reconsideration letter from Dr. dated 05/13/08

A PLN-11 form from the insurance carrier dated 05/20/08

An explanation of off work status from Dr. dated 05/28/08

Fitting notes from Dr. dated 05/29/08

Evaluations with M.D. dated 06/19/08 and 02/06/09

Unimed Direct Pre-Authorization Intake Forms dated 06/27/08 and 07/09/08

A letter from Ombudsman, dated 06/27/08

A DWC-69 form from Dr. dated 07/08/08

A letter "To Whom It May Concern" from Dr. dated 07/28/08

A letter from Benefit Review Officer at TDI, dated 08/01/08

A response to letter of clarification concerning extent of compensable injury from Dr. dated 08/07/08

A Notice of IRO Decision from Director of Operations, dated 08/08/08

A Report of Medical Evaluation from M.D. dated 10/09/08

A DWC-73 form from Dr. dated 10/09/08

A Decision and Order from TDI dated 01/12/09

A request for an MRI of the lumbar spine from Dr. dated 01/22/09

A letter of adverse determination for a repeat lumbar MRI, according to the Official Disability Guidelines (ODG), from D.O. dated 02/11/09

A letter of adverse determination for a repeat lumbar MRI, according to the ODG, from M.D. dated 02/20/09
An IRO Summary dated 03/10/09
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

The Employer's First Report of Injury or Illness form stated the patient slipped and fell on xx/xx/xx and strained her thigh(s). An EMG/NCV study on 11/15/06 was unremarkable. On 01/05/07, Mr. recommended physical therapy three times a week for two weeks. On 02/14/07, Dr. placed the patient at Maximum Medical Improvement (MMI) with a 0% whole person impairment rating. MRIs of the right knee and lumbar spine interpreted by Dr. on 03/29/07 showed posterior horn medial meniscus tears with myxoid degeneration and mild patellar subluxation, as well as a small annular tear at L1-L2 and a small herniated disc with extrusion at L2-L3. On 03/30/07, Dr. felt the patient was not at MMI. On 06/20/07, Dr. performed a right hip injection. On 11/28/07, Dr. performed a right knee Cortisone injection. A PPE with Dr. on 03/06/08 indicated the patient functioned at the light physical demand level. On 03/24/08, 05/08/08, and 07/10/08, Dr. recommended spinal epidural steroid injections (ESIs). On 05/13/08, Dr. wrote a request for reconsideration letter for the ESIs. On 07/08/08, Dr. felt the compensable injury extended to a lumbar sprain/strain, a right knee strain, and a right hip strain. On 08/07/08, Dr. wrote a response to a letter of clarification concerning the extent of compensable injury. On 09/03/08, Dr. noted the patient had been scheduled for a Contested Case Hearing (CCH) on 09/11/08. On 10/09/08, Dr. felt the patient was able to work at full duty. On 01/12/09, a Decision and Order indicated that the compensable injury included the lumbar and right knee MRI findings of 03/29/07. On 02/06/09, Dr. recommended an MRI of the right knee. On 02/11/09, Dr. wrote a letter of adverse determination for a repeat MRI of the lumbar spine. On 02/20/09, Dr. also wrote a letter of adverse determination for a repeat MRI of the lumbar spine.

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

The requested repeat lumbar MRI scan is not medically reasonable or supported by the evidence based ODG. The ODG indications for Magnetic Resonance Imaging (MRI) include lumbar spine trauma with neurological deficit, lumbar spine trauma, uncomplicated low back pain with suspicion of cancer infection, uncomplicated low back pain with radiculopathy after at least one month of conservative therapy or sooner if severe or progressive neurological deficit is present, uncomplicated low back pain with a history of prior lumbar surgery, uncomplicated low back pain with cauda equina syndrome, traumatic myelopathy with neurological deficit, painful myelopathy, sudden onset myelopathy, step-wise progressive myelopathy, slowly progressive myelopathy, infectious disease patient with myelopathy, or oncological patient with myelopathy. It can clearly be seen from the indications of the evidence based ODG that the patient does not

meet any of these criteria. MRI scans are the test of choice for a patient with prior back surgery. Repeat MRI scans are indicated only if there has been progression of neurological deficit (Bigos, 1999), (Mullin 2000), (ACRR 2000), (AAN 1994) (Aetna 2004), (Airaksinen, 2006), and (Chou 2007). There is support for MRI scan depending on symptoms and signs to rule out serious pathology such as tumor, infection, fracture, and cauda equina syndrome. Patients with severe or progressive neurological deficits for lumbar disc herniation or subjects with lumbar radiculopathy who do not respond to initial appropriate conservative care are also candidates for lumbar MRI scan to evaluate potential for spinal intervention including injections or therapy. It is clear from the above indication that the present patient meets none of the criteria of the ODG. Therefore, the requested repeat lumbar MRI is neither reasonable nor necessary.

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 AND KNOWLEDGE BASE
- 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)**

Bigos, 1999), (Mullin 2000), (ACRR 2000), (AAN 1994) (Aetna 2004),
(Airaksinen, 2006), and (Chou 2007).