

SENT VIA EMAIL OR FAX ON
Nov/23/2009

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/22/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat Lumbar MRI spine w/o, X-Ray lumbar spine; EMG

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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 9/29/09 and 10/16/09

Dr. 9/10/09

2/27/09, 3/27/09

Consultants 3/12/09, 04/02/2009, 04/15/2009, 5/7/2009

Dr. clinic notes 07/10/2009, 08/18/2009

PATIENT CLINICAL HISTORY SUMMARY

This is a male with a date of injury xx/xx/xx. He complains of pain to the left back with no radiation. He has had PT and two lumbar ESIs and massage therapy. He has also had facet injections. He has also been diagnosed with a major depressive disorder. His neurological examination is normal. A prior MRI was done, but the report was not included for review. Apparently there was a prior EMG done, which was consistent with a left L5 radiculopathy. The provider is requesting a lumbar MRI, x-ray of the lumbar spine, and an EMG.

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

The MRI of the lumbar spine is not medically necessary. According to the ODG, "Low Back" chapter, serial MRIs are indicated only when there is progression of neurological deficits. There is no evidence that the claimant has any indication of neurological deficits or has had any significant change in his symptoms since the last MRI.

The x-ray of the lumbar spine with flexion and extension is not medically necessary. According to the ODG, "Low Back" chapter, flexion and extension films of the lumbar spine may be indicated to help evaluate a symptomatic spondylolisthesis. There is no evidence that this claimant has a spondylolisthesis.

The EMG is not medically necessary. It appears that the claimant has already had one, and there is no explanation for the need for an EMG from the provider in his clinic note. According to the ODG, "Low Back" chapter, an EMG "may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious". In this case, there is nothing to suggest by examination or by history that the claimant is suffering from a radiculopathy. His pain is non-radiating. Therefore, the EMG is not medically necessary.

References/Guidelines

ODG "Low Back" chapter

MRI

Indications for imaging -- Magnetic resonance imaging (MRI):

Repeat MRI's are indicated only if there has been progression of neurologic deficit.

EMG

...may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious

Flexion and extension films

May be indicated to evaluate a symptomatic spondylolisthesis

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

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)