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Notice of Independent Review Decision

DATE OF REVIEW: 10/06/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

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.

Lumbar MRI - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

A CT scan of the lumbar spine interpreted by Dr. (no credentials were listed)
dated 02/02/09

Evaluations with , D.O. dated 03/17/09, 04/09/09, 04/30/09, 05/08/09, 05/29/09, 06/19/09, 07/21/09,
An impairment rating evaluation with , M.D. dated 03/27/09
An EMG/NCV study interpreted by , M.D. dated 05/15/09
An evaluation with M.D. dated 06/30/09
An evaluation with , M.D. dated 07/22/09
A letter of denial for a lumbar MRI, according to the Official Disability Guidelines (ODG), from , D.O. dated 08/03/09
A letter of denial for a lumbar MRI, according to the ODG, from , M.D. dated 08/31/09
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

A lumbar CT scan on 02/02/09 showed post L4-L5 laminectomy changes, mild facet joint arthrosis, and hyperlordosis of the lumbar curvature. On 03/17/09, Dr. recommended Celebrex, Lortab, Amrix, and Ultracet. On 03/27/09, Dr. placed the patient at Maximum Medical Improvement (MMI) and gave him a 5% whole person impairment rating. An EMG/NCV study interpreted by Dr. on 05/15/09 was unremarkable. On 06/30/09, Dr. recommended an aggressive back strengthening exercise program with possible conditioning program, physician follow-up visits every three to four months, and continued Lortab with weaning of the muscle relaxers. On 08/03/09, Dr. wrote a letter of denial for a lumbar MRI. On 08/31/09, Dr. also wrote a letter of denial for an MRI.

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

A CT scan dated 2/2/09 demonstrated post surgical changes with no evidence of spinal canal and intrapedicular screws at L4-5 from a PLIF performed on 11/15/05. On the date of injury, the patient was picking up a heavy weight and felt a pull in his back and sustained a sprain/strain of the lumbar spine, which was confirmed by on his Designated Doctor Evaluation on 03/27/09. During the treatment rendered by Dr. the patient did not develop any radicular symptoms and the EMG/NCV study performed by Dr. showed no evidence of abnormality, although he complained of weakness when evaluated by Dr. . It should be noted the examination was non-specific demonstrating global weakness on the right (not likely to be physiological in nature). The patient has experienced no physiological change in his neurological examination and has been adequately examined with CT scan. In the absence of objective change, good medical practice, and the ODG would determine that there is no medical necessity to repeat an imaging study. Therefore, the requested lumbar MRI is neither reasonable nor necessary and the previous adverse determinations should be upheld.

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)