

SENT VIA EMAIL OR FAX ON
Oct/15/2009

Applied Assessments LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/15/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI lumbar without contrast long train fast spin echo

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

Board Certified Orthopedic Surgeon

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

Procedure, 10/26/07

Office notes, Dr., 12/20/07, 08/26/08, 02/09/09, 07/22/09

CT lumbar/post myelogram, 01/18/08

X-rays lumbar, 01/24/08

Office notes, Dr., 02/14/08, 03/21/08, 04/03/08, 04/30/08, 08/06/08

Operative report, 03/21/08

Consultation, Dr., 04/14/08

Peer review, 08/18/09, 09/02/09

PATIENT CLINICAL HISTORY SUMMARY

This is a female claimant who is reportedly status post lumbar anterior fusion L4-5 in 1992 with revision surgery of posterior lumbar fusion L4-5 in 1995. The claimant has been diagnosed with post laminectomy syndrome with reported low back pain and bilateral leg

pain. Lumbar x-rays in April 2009 showed a solid fusion L4-5 with no hardware failure and no instability. A physician record dated 08/06/09 noted the claimant with low back pain and significant bilateral leg pain and left leg weakness. A lumbar MRI was recommended to identify a neuro occlusive lesion.

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

It would not appear that there have been any progressive neurologic deficits since the most recent surgical intervention performed in this case. The ODG indicates the repeated studies are indicated if there has been a progression of a neurologic deficit. The same cannot be confirmed in the records available. The Reviewer would not be able to recommend the proposed study as medically necessary.

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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