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Notice of Independent Review Decision

DATE OF REVIEW: 10/30/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The service under dispute includes the prospective medical necessity of a lumbar MRI.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. This reviewer has been practicing for 15 years and refers for this type of procedure in daily practice.

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)

The reviewer agrees with the previous adverse determination regarding includes the prospective medical necessity of a lumbar MRI.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: MD and UR unit.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr. : 5/19/09 office note.

: 2 pages of residential home listings, 3/23/09 IME report by MD, 3/23/09 report by MD, 9/28/09 denial letter for MRI by MD and 10/7/09 denial letter by , MD.

We did not receive a copy of the ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male. He was injured when his car was rear-ended at work. The patient underwent fusion and instrumentation on 11/14/07 then hardware removal in May 2008. An MMI date of 04/01/08 rated the patient with a 10% impairment. An RME on 3/23/09 indicated no additional tests were warranted at that time, but possibly in future if symptoms changed. As per the 5/19/09 office visit with Dr. a physical exam showed no gross motor defects and symmetric knee and ankle jerks, and no paravertebral muscle spasm. There was no notation of progression of neurologic deficit exists in any notes.

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

According to the ODG: MRI's are the test of choice for patients with prior back surgery. Repeat MRI's are indicated only if there has been progression of neurologic deficit. Considering the patient had no gross motor defects and symmetric knee and ankle jerks, and no paravertebral muscle spasm on the exam dated 5/19/09, this patient does not meet the ODG criterion for this procedure. The lumbar MRI is not medically necessary according to the ODG.

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 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)