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Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 09/17/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar MRI without contrast

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 without contrast - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X-rays of the lumbar spine interpreted by , M.D. dated 06/24/08
Evaluations with , N.P.-C. dated 06/24/08, 06/27/08, and 06/30/08
An MRI of the lumbar spine interpreted by an unknown provider (no name or signature was available) dated 06/25/08
An evaluation with , M.D. dated 07/09/08
Evaluations with , M.D. dated 08/11/08, 08/25/08, 10/02/08, 10/31/08, 12/01/08, 12/29/08, and 01/19/09
Evaluations with ., M.D. dated 11/20/08, 01/23/09, 03/19/09, 04/16/09, 04/30/09, 06/11/09, and 07/24/09
A procedure report from Dr. dated 01/16/09
A behavioral medicine evaluation with , M.S., L.P.C. and , Ph.D. dated 02/03/09
An evaluation with M.D. dated 03/19/09
An operative report from Dr. dated 03/31/09
A conversation with the patient's wife and Dr. dated 04/01/09
A request for a lumbar MRI from Dr. dated 06/11/09
Letters of denial, according to the Official Disability Guidelines (ODG), from CorVel dated 07/23/09, 08/10/09, and 08/28/09
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

X-rays of the lumbar spine interpreted by Dr. on 06/24/08 were unremarkable. An MRI of the lumbar spine interpreted by an unknown provider on 06/25/08 showed diffuse disc bulges at L4-L5 and L5-S1. On 07/09/08, Dr. recommended physical therapy, Mobic, Zanaflex, and Lortab. On 08/25/08, Dr. recommended a selective nerve root block. On 10/02/08, Dr. recommended an IRO and surgical consultation. A lumbar epidural steroid injection (ESI) was performed by Dr. on 01/16/09. On 02/03/09, Ms. and Dr. recommended a referral to behavioral medicine therapists or an addictionologist and more frequent clinic visits for medication. A left L5-S1 discectomy was performed by Dr. on 03/31/09. On 06/11/09, Dr. recommended an MRI of the lumbar spine, possible spinal injection, Lodine, Norco, and Flexeril. On 07/23/09, 08/10/09, and 08/28/09, wrote letters of denial for a lumbar MRI.

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

The patient does not have any clinical evidence of ongoing neurological deficits or change in his neurological status since the time of the discectomy, infection, or tumor. The patient received a lumbar laminectomy in the absence of radiculopathy and has had ongoing lower back pain. There was no reason to assume that the new MRI findings would be any different from the old ones. At this time, an MRI would not be indicated. Therefore, the requested lumbar MRI without contrast would be 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)