

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
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Notice of Independent Review Decision

DATE OF REVIEW: March 23, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Three phrase bone scan.

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

Board Certified Neurologist, Diplomate, American Board of Pain Medicine

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

Medical records from the Carrier/URA include:

- Official Disability Guidelines, 2008
- 09/21/09, 09/24/09, 10/09/09, 10/27/09, 02/19/10
- M.D., 09/28/09, 10/09/09, 02/19/10, 03/10/10

- Therapy and Diagnostics, 09/08/09, 10/09/09
- Imaging and Diagnostics Center , 10/02/09, 10/07/09

Medical records from the Treating Doctor/Provider include:

- M.D., 08/30/05, 12/06/05, 01/19/06, 04/20/06
- M.D., 09/18/09, 09/20/09, 09/21/09, 09/25/09, 09/28/09, 10/01/09, 10/09/09, 02/19/10, 02/22/10, 02/25/10, 03/10/10
- Pharmacy, 09/18/09
- 09/24/09, 09/28/09, 09/29/09, 10/09/09, 10/22/09
- Therapy and Diagnostics, 09/28/09
- Imaging and Diagnostics Center, 10/02/09

PATIENT CLINICAL HISTORY:

The patient is a female with a date of injury on xx/xx/xx, with an MRI in October of 2009 documenting a prior left L4-5 laminectomy on the right, with no significant stenosis or granulation tissue. There was no significant pathology noted at L5-S1. There was mild disc bulge at L3-4, with mild-to-moderate spinal stenosis. An EMG study was not provided. There is noted left decreased dorsiflexion and difficulty with heel walking. There were findings running the opposite of the previous surgery. The diagnosis of lumbar radicular syndrome, gradually over six months worsened.

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

I uphold the failure to approve a three-phrase bone scan. It is not recommended except for bone infection, cancer or arthritis. There is no evidence of any of these diagnoses on the patient’s clinical presentation, which is clearly documented to be spondylosis. There is nothing by notes that suggest a complex regional pain syndrome.

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)