

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

**DATE OF REVIEW:** April 20, 2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

MRI of the Lumbar Spine.

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

AMERICAN BOARD OF ORTHOPEDIC SURGEONS

**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
- Employers First Report of Injury or Illness, xx/xx/xx
- DWC 61, Initial Medical Report, 02/01/93
- DWC 64, Specific and Subsequent Medical Report, 03/31/93, 06/18/93, 10/06/93
- Group, 06/10/93
- xxxxxxxxxxxxxxxx, P.A., 08/25/93
- M.D., 03/24/94, 11/23/94, 01/31/95, 05/27/97, 08/14/97
- xxxxxxxxxxxx, 08/17/94, 04/11/95, 05/31/95, 08/18/95, 02/27/96, 07/18/97, 01/19/98, 04/17/97, 09/22/98, 04/29/98, 11/08/00, 02/16/01, 05/17/01
- M.D., 05/17/95
- M.D., P.A., 01/31/96, 02/12/96, 09/24/97, 10/30/97, 11/09/04, 11/29/06, 01/16/08
- xxxxxxxxxxxx, 06/13/96
- xxxxxxxxxxxxxxxx, 03/08/00
- M.D., 07/20/00
- xxxxxxxxxxxx, 02/02/01
- Dr. 01/11/02, 02/01/02

- Dr. 04/03/02, 04/10/02, 06/03/02, 10/17/03, 11/06/03, 12/08/03, 06/02/04, 06/30/04, 09/29/04, 03/30/05, 04/27/05, 05/25/05, 07/07/05, 10/05/05, 10/25/06, 01/10/07, 02/15/07, 04/18/07, 06/13/07, 08/22/07, 11/21/07, 03/26/08, 01/06/09, 01/23/09, 05/27/09, 07/22/09, 10/28/09, 12/02/09
- Images, Inc., 05/08/03
- M.D., P.A., 12/17/03
- xxxxxxxxxxxx, 04/15/04, 11/17/05, 01/08/09
- xxxxxxxxxxxx, 06/08/05
- xxxxxxxxxxxxxxxxxxxx, 09/24/07
- 06/22/09, 12/07/09, 02/01/10, 02/26/10
- xxxxxxxxxxxxxxxxxxxxxxxx, P.A., 01/27/10
- M.D., 02/19/10
- Texas Department of Insurance, 03/31/10

Medical records from the Treating Doctor/Provider include:

- Dr., 07/22/09, 10/28/09, 12/02/09, 02/24/10
- Texas Department of Insurance, 03/31/10

**PATIENT CLINICAL HISTORY:**

The previous adverse determination should be upheld.

This patient, with a remote history of a lumbar strain over xxxx years ago, has no evidence of any progressive neurologic symptoms. He is complaining of back pain, which most likely is the result of his ankylosing spondylitis. The medical records do not determine the presence of any radicular signs or symptoms. His motor examination is normal. His sensory examination is normal. The ODG does indicate that repeat MRI scans are indicated when there is a suspicion of cancer or infection, when there is radiculopathy, when there is prior lumbar surgery, or when there is the presence of cauda equina syndrome. There is no evidence of myelopathy, or any evidence of trauma. Therefore, the patient does not meet the criteria for a repeat MRI.

In regards to the patient’s current symptoms, they are not related to the remote sprain/strain of 16 years ago, more likely related to the ankylosing spondylitis. However, the criteria for which the decision is made is irrelevant to the causality.

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

The brief clinical history is as above. This is a patient whose date of birth is xx/xx/xx, who was injured on xx/xx/xx, when he was twisting while washing xxxx. The patient has not had any lumbar spine surgery. He has been diagnosed incidentally with ankylosing spondylitis. He has had cervical surgery and has had a carpal tunnel release.

The criteria utilized are 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)