

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

DATE OF REVIEW: June 9, 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:

DIPLOMATE, AMERICAN BOARD OF 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Medical records from the URA include:

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Medical records from the Provider include:

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PATIENT CLINICAL HISTORY:

The patient is a male who fell through a hole in the ceiling where he was working. He sustained a right shoulder injury, that ultimately required a total shoulder replacement arthroplasty, and also a lumbar injury. The request is for a lumbar MRI by, M.D.

The previous imaging of a lumbar MRI on xxxxxx, revealed only pre-existent findings of a previous laminectomy and discectomy at the left L4-5 with moderate decreased disc space and endplate changes. The annular bulging and facet hypertrophy produced moderate bilateral foraminal narrowing that was lateralized to the right (the patient's symptoms are left sided). The L5-S1 disc level revealed only minimal degenerative changes also that lateralized to the right.

There is no documentation of physical therapy treatment. Dr. has not documented objective signs of radiculopathy. A designated doctor also did not document objective signs of radiculopathy and found a normal motor, sensory, and reflex examination (just as Dr. has documented) and awarded 0% whole person impairment for the lumbar spine.

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

The ODG does not recommend lumbar imaging unless there are clear objective signs of radiculopathy (loss of relevant reflexes and/or 2 cm unilateral atrophy of the lower extremity). Even in the presence of true radiculopathy, the ODG requires at least one month of conservative treatment, such as physical therapy and a home exercise program.

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)