

Notice of Independent Review Decision

DATE OF REVIEW: JUNE 1, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Magnetic Resonance (EG, Proton) Imaging, spinal canal and contents, lumbar; without contrast material.

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

This reviewer is licensed by Texas Board of Chiropractic Examiners with 14 years of experience.

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

On December 15, 2009, M.D. evaluated the claimant. The claimant stated he injured his low back on xx/xx/xx while handling bags of beans weighing approximately 100 pounds. Chief Complaint: Low back pain mostly on the left side, tingling and numbness down his left buttock. Diagnosis: Low Back Strain/Sprain. Left SI Joint radiculopathy.

On December 21, 2009, the claimant underwent at PPE with Health Centers. The claimant tested in a Light PDL Category.

On December 22, 2009, M.D. performed a follow-up evaluation on the claimant. Dr. noted that the claimant was unchanged since his initial evaluation. Recommendations: EMG/NCV. Diagnosis: Low Back Strain/Sprain. Left SI Joint radiculopathy.

On January 8, 2010, M.D. performed a follow-up evaluation on the claimant. Dr. noted that the claimant was unchanged since his initial evaluation. Recommendations: EMG/NCV. Diagnosis: Low Back Strain/Sprain. Left SI Joint radiculopathy.

On January 15, 2010, MRI of the lumbar spine was performed, read by M.D. Impression: L5-S1 central disc herniation extrusion with deformity of the right S1 nerve root sleeve, minimal facet arthropathy, and lateral recess stenosis.

On February 15, 2010, per the operative report, M.D. performed the following procedures: Hemilaminectomy L5-S1, left, nerve root decompression, removal of HNP at L5-S1, and epidural depo-medrol and marcaine muscle injection.

On April 5, 2010, D.O., a family medicine physician, performed an utilization review on the necessity of a repeat MRI of the lumbar spine. Decision: The claimant's records received do not reveal that he has any neurological deficit/abnormality or progression of a neurological deficit; therefore, request is denied.

On May 5, 2010, D.C. responded to the denial with a letter of medical necessity. D.C. states, "This patient has had a failed surgery and might need another surgery."

On May 12, 2010, D.C. performed a pre-authorization on the request for a MRI of the lumbar spine. Decision: Request is denied based on lack of clinical information.

On May 25, 2010, D.C. performed an appeal pre-authorization on the request for a MRI of the lumbar spine. Decision: Request is denied based on no current examination findings have been provided to show a progressive neurologic deficit.

PATIENT CLINICAL HISTORY:

This claimant is injured his lumbar spine while handling bags of beans weighing approximately 100 pounds.

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

The decision is upheld, as there is no medical documentation of progression of neurologic deficit.

ODG Guidelines Criteria for a Repeat Lumbar MRI:

MRIs (magnetic resonance imaging)	Repeat MRI's are indicated only if there has been progression of neurologic deficit. (Bigos, 1999) (Mullin, 2000) (ACR, 2000) (AAN, 1994) (Aetna, 2004) (Airaksinen, 2006) (Chou, 2007)
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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)**