

C-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: May/19/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI of the lumbar spine with and without contrast 72148

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

M.D., 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

xxxxx Denial Letters, 2/24/10, 3/22/10

xxxxx 2/19/10, 2/16/10

D.D. 2/1/10, 1/28/10, 1/25/10, 1/4/10

xxxxx 1/20/10

xxxxx 3/12/10

ODG

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who, according to the records provided, had a work related injury and subsequently underwent a lumbar laminectomy. Postoperatively he has had significant therapy and other conservative care. Current examination reveals painful range of motion, positive straight leg raising on the right, and decreased sensation at the S1 level. The patient's doctor notes in a letter that there has been progression of the deficit with increased problems on the right hand side, post surgery. The physical examination reveals pain with range of motion and decreased sensation over the L5 and S1 dermatomes noted. The current request is for a repeat MRI scan with and without contrast.

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

The previous surgery, the failure to improve, and the record that the same deficit has now increased, are all reasons for which an MRI is indicated per the ODG in this injured worker's case. The patient's doctor notes in a letter that there has been progression of the deficit with increased problems on the right hand side, post surgery. The Official Disability Guidelines

and Treatment Guidelines state that MRIs are the test of choice for patients with prior back surgery and that repeat MRIs are indicated if there has been progression of neurologic deficit. Therefore, upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be overturned. The reviewer finds that medical necessity exists for MRI of the lumbar spine with and without contrast 72148.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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)