

US Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/22/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat Lumbar MRI

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

M.D. Board Certified 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

ODG Treatment Guidelines

Utilization review determination 09/16/11

Reconsideration / appeal of adverse determination 10/25/11

Preauthorization request repeat lumbar MRI 09/11/11

Appeal request repeat lumbar MRI 10/07/11

Office note Dr. 01/10/11

Family Care office notes 07/21/11-09/20/11

Designated doctor evaluation 05/09/11

Commissioner Order 7/28/2011

PATIENT CLINICAL HISTORY SUMMARY

This patient is a male whose date of injury is xx/xx/xx. He was accident. He complains of low back pain and right leg pain. MRI of lumbar spine reportedly revealed bulging discs at L4-5 and L5-S1. Repeat MRI has been recommended.

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

This man sustained injury. He has complaints of low back pain and right leg pain. Previous MRI is noted to have revealed evidence of L4-5 disc protrusion. There is no documentation of significant change in symptoms or progression of neurologic deficit to support need for repeat MRI scan of lumbar spine. Per ODG guidelines, repeat MRI is not routinely recommended and should be reserved for significant change in symptoms and / or findings suggestive of significant pathology. There is no evidence of progressive neurologic deficit, significant change in symptoms, or findings suggestive of significant pathology such as infection, fracture, or neurocompression. The ODG guidelines have not been satisfied for

repeat MRI. The reviewer finds no medical necessity for repeat lumbar MRI.

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)