



Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

Notice of Independent Review Decision

DATE OF REVIEW: 12/15/10 (AMENDED 01/03/11)

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar MRI without contrast

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

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)

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.

Lumbar MRI without contrast - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

DWC-73 forms from M.D. dated 04/21/10, 05/03/10, and 05/10/10
DWC-73 forms from M.D. dated 05/18/10 and 06/01/10

An MRI of the thoracic spine interpreted by M.D. dated 05/25/10
A DWC-73 form from M.D. dated 06/09/10
DWC-73 forms from P.A. dated 06/23/10 and 07/09/10
Evaluations with M.D. dated 08/12/10 and 10/04/10
A preauthorization request/letter of non-authorization for a lumbar MRI, according to the Official Disability Guidelines (ODG) from M.D. dated 08/26/10
DWC-73 forms from M.D. dated 08/28/10 and 09/17/10
DWC-73 forms from M.D. dated 10/15/10 and 11/18/10
A peer review report from M.D. dated 10/25/10
Letters of non-authorization for a lumbar MRI, according to the ODG, from dated 10/26/10 and 11/24/10
A referral/consultation to from Dr. dated 11/04/10
A peer review report from M.D. dated 11/22/10
A letter of reconsideration from dated 11/22/10
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

On 04/21/10, Dr. kept the patient on modified work duty through 05/03/10 and recommended physical therapy twice a week for three weeks. On 05/18/10, Dr. kept the patient on modified work duty through 06/01/10. An MRI of the thoracic spine interpreted by Dr. on 05/25/10 was unremarkable. On 06/09/10, Dr. kept the patient on modified work duty through 06/29/10 and recommended physical therapy three times a week for four weeks. On 07/09/10, Ms. continued the patient on modified work duty through 08/10/10 and referred him to, M.D. On 08/12/10 and 10/04/10, Dr. recommended an MRI of the lumbar spine, Robaxin, Vicodin, and Ibuprofen. On 08/25/10, Dr. wrote a letter of non-authorization for the lumbar MRI. On 10/15/10, Dr. took the patient off work for four weeks and recommended physical therapy and a lumbar MRI. Dr. wrote a letter of non-authorization for the lumbar MRI on 10/25/10. On 10/26/10 and 11/24/10, wrote letters of denial for the lumbar MRI. On 11/04/10, Dr. recommended a referral to Dr. for spinal injections. On 11/18/10, Dr. kept the patient off work and again recommended a pain specialist evaluation, physical therapy, and a lumbar MRI. Dr. wrote a letter of non-authorization for the MRI on 11/22/10.

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

This patient does not meet the criteria set forth in the Official Disability Guidelines (ODG) for a lumbar MRI. The patient does not have radiculopathy. He has no evidence of structural failure with normal x-rays. The patient does not have any evidence of tumor, infection, or other life threatening process. Therefore, he does not meet the criteria for an MRI, according to the ODG. Therefore, a lumbar MRI without contrast would not be reasonable or necessary and the previous adverse determinations should be upheld.

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)