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**Notice of Independent Review Decision**

**IRO REVIEWER REPORT – WC (Non-Network)**

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**DATE OF REVIEW:** 11/11/11

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

MRI of the lumbar spine 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.

MRI of the lumbar spine without contrast - Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

A Physical Performance Baseline with dated 09/29/11  
Radiology Prior Authorization Request Forms from with received dates of  
10/04/11 and 10/12/11

An adverse determination letter from with IMO dated 10/10/11  
An adverse determination - amended letter from with IMO dated 10/20/11  
Two undated Radiology Order Forms for an MRI of the lumbar spine  
Two undated Worker's Compensation Information/Verification Sheets  
Two undated Workers' Compensation Demographics Sheets from Elite Healthcare & Rehabilitation  
The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

### **PATIENT CLINICAL HISTORY**

The patient underwent a physical performance baseline on 09/29/11. It was noted her required physical demand level was sedentary and her current physical demand level, based on the testing, was below sedentary. It was felt the patient demonstrated a consistent performance and reproducible results when comparing her physical assessment to her functional performance between the repeated activities. On 10/04/11 and 10/12/11, faxed a radiology prior authorization request forms for an MRI of the lumbar spine. provided an adverse determination letter on 10/10/11 for the lumbar MRI without contrast. On 10/20/11, also provided an adverse determination letter for the lumbar MRI without contrast.

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

The slip and fall that occurred was four years prior. The medical records do not indicate any objective medical change. The patient had returned to full duty after the slip and fall and has been diagnosed with various syndromes such as myofascial pain syndrome and fibromyalgia. Per the ODG, an MRI without contrast at this time would not be reasonable or necessary given the normal neurological examination. Current medical research has indicated that repeating an MRI in the face of a constant medical examination will not yield useful medical information.

The ODG also does not endorse the routine use of MRI for a "fishing" expedition. MRI is indicated for thoracic spine trauma or lumbar spine trauma with neurological deficit, suspicion of infection, radiculopathy, prior surgery, or myelopathy. This patient does not meet those diagnoses and thus, an MRI would not yield useful diagnostic information. The ODG does not recommend the performance of an MRI in this situation. Therefore, the requested MRI of the lumbar spine without contrast is neither reasonable nor 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 AND KNOWLEDGE BASE
- 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)